STATE OF CALIFORNIA

MANAGED HEALTH CARE IMPROVEMENT TASK FORCE

BUSINESS MEETING

AFTERNOON SESSION

2:00 P.M.

Friday, November 21, 1997

1201 K Street, Chamber of Commerce Building

12th Floor, Conference Room

Sacramento, California

REPORTED BY:
Joanna Austin,
CSR, RPR 10380
Our File No. 41049

APPEARANCES:

Dr. Alain Enthoven, Chairman

Dr. Philip Romero, Executive Director

Alice Singh, Deputy Director

Patty Skubik

Stephanie Kauss

Bernard Alpert, M.D.
Rebecca L. Bowne
Donna H. Conom, M.D
Barbara L. Decker
Nancy Farber
Jeanne Finberg
Bradley Gilbert, M.D.
Diane Griffiths
Terry Hartshorn
William Hauck
Michael Karpf, M.D.
Clark E. Kerr
Peter Lee
J.D. Northway, M.D.
Maryann O'Sullivan
John A. Perez
Anthony Rodgers
Dr. Helen Rodriguez-Trias
Ellen B. Severoni
Bruce W. Spurlock, M.D.
David J. Tirapelle
Ronald A. Williams
Allan S. Zaremberg
Steven R. Zatkin

DR. ENTHOVEN: Will the members please take their seats and we will resume our deliberations. The next papers we're going to deal with are going to be health industry profile and the impact of managed care on quality access and cost. Pursuant to today's legislation we will just be adopting the findings and recommendations in each case. There are no recommendations. We will just be adopting the findings. We'll start with health industry profile.

MR. PEREZ: Which tab?

MS. SINGH: V E.

We have dead mikes today. We tried to save a little bit of money and obviously it didn't work.

DR. ROMERO: That was my announcement. Our vendor gave us faulty equipment and admits as much so we're not paying for it. So you get what you pay for. Therefore, we will not have audio visual assistance for the rest of today, so I ask you to speak quite loudly. And I direct that particularly to people at the front of the room so the back of room can hear them.

MR. PEREZ: Can we ask if there's anybody that has special needs in terms of being able to move them up further from the audience?

DR. ROMERO: Good idea.

DR. NORTHWAY: Some of us enjoy only hearing half of what's going on.

DR. ROMERO: If anyone there has particular difficulty hearing us because we're constrained by lack of

amplification, I invite you to feel free to move your chair further forward or move to the front row of the audience. I wish I could help you more, but that's all we can offer.

DR. ENTHOVEN: For me, I'm just grateful we don't have rats running around on the floor.

MR. LEE: It's early yet, Alain. I'm sure we won't. I'm sorry.

DR. ENTHOVEN: Although we've allocated an hour for each of these, I think we ought to be able to do these much quicker, in part for reasons I will explain now. These are the papers on health industry profile and quality access cost. Both of these papers have been thoroughly discussed and completely revised based on numerous inputs from numerous members twice in the case of the health industry profile. Every interested person has had an opportunity to suggest changes, and we've tried very hard to respond constructively to all suggestions.

What I'm going to want to know at the outset is whether the task force is ready to vote on these papers.

MS. SINGH: Just the findings --

DR. ENTHOVEN: Just the findings section.

MS. FINBERG: Pages one to eight.

MR. PEREZ: Are we going to take public comments on this before --

DR. ENTHOVEN: Yes.

I do want to say the following about these

papers now. I think we have come to the time when it's appropriate to have an up our down vote. We've put an enormous amount of effort trying very hard to accommodate people. I do believe that. In fact, we have bent over backwards to accommodate antimanaged care people. There are things in the paper that I am personally embarrassed about. Such as, when we discuss the health industry and managed care, we somewhere start talking about HMOs in this state. And let me say, the background of this was we had tried to say a few times by way of illustration -- let's say lifeguard HMOs tried to improve quality by doing the following things. Then people came on and said, "Look, that's advertising HMOs. Take that out."

So the politically correct thing became to do is to say, "Don't use the name of any HMO." So we have a paper on health care -- health industry profile which does not have the phrase, "Kaiser Permanente." We talk about the rise of managed care. It starts with my dear friend, Paul Elwood; it doesn't start where it really started which was with Ross Loos and Kaiser Permanente.

MR. ZATKIN: That's all right. I'll take the survey results from this morning.

(Laughter.)

DR. ENTHOVEN: I just think frankly it's ridiculous. So I think we have to vote on these now. And I'm totally reconciled to the idea that this may go forward to everybody saying only six members of the task force voted for it. But if we try to push the ball

farther in one way or the other, I think we will lose people on the other side, including me. If there's one more anti-managed care thing in here I will vote against it. I'm just embarrassed by how far this went. But I don't blame my staff because I said to them, please try to respond very constructively and sympathetically and deal with the concerns of the members and so forth.

So I put the paper before you. We'll have a maximum of an hour -- we are going to have a half hour for this. And by the end of that, we will have a vote, even if it's a negative vote.

Do I hear a motion to adopt this paper? Sorry. First we must have testimony from the general public who wants to speak on this issue of the health industry profile. We have Catherine Dodd, American Nurse's Association of California.

Ms. Dodd, welcome, if you're here.

MEMBER: She's eating lunch.

DR. ENTHOVEN: We have three minutes. She's not here. We will proceed without her.

Do I hear a motion?

MR. RODGERS: Second.

DR. ENTHOVEN: The motion has been made forward to adopt the paper -- the findings. This is just called "findings."

Discussion. Michael.

DR. KARPF: Alain, I would hope we could adopt this very quickly. At the last discussion, Nancy

Farber and I had asked that there be a paragraph about medical loss ratio, and that did make it into the body of the paper, but it didn't make it into the summary. I would hope we could usurp something from that, say that there is some medical loss ratios, as you pointed out. The county techniques are not precise at this point in time, but were they to be more standardized, then it would help consumers understand what part of their health care dollars are going to health care and what is going to administration and other areas.

MR. LEE: Can I make a procedural --

DR. ENTHOVEN: Is there an objection to that as a technical amendment that would be delegated to me, that is, to pick up something in the back and moving it to the front?

MR. LEE: No objection.

I was going to try to -- in a similar manner. That's great.

DR. ENTHOVEN: Nancy Farber.

MS. FARBER: As a technical issue, on page 19 you have your schematic overview of California's health care regulatory structure. I sent information to your staff at the last meeting. I gave you a comprehensive list of who regulates hospitals. It's not included here. I think it's a gross misrepresentation to say that the Department of Health is the only regulatory agency having control over general acute hospitals.

DR. ENTHOVEN: This is meant to be, what we

say in the quality improvement terms, the high level diagram and not a complete thing. In the paper on regulatory organization, we have in great detail --

DR. ROMERO: As I recall, Nancy, I think we took your list more or less verbatim in the regulatory organization paper. That will be established when we talk about that paper later on today.

MS. FARBER: You look at it and think, "Oh, the poor health coverage companies. They have three agencies looking at them, and hospitals and clinics are running around loose with only one agency looking over their shoulder. I think that's misleading.

DR. ENTHOVEN: It will be corrected when you get the full material. My parlimentarian reminds me we're just discussing the findings section, which goes up to -- at this time which goes up to page 8.

So we have a friendly technical minute to bring medical loss ratio commentary into the -- other comments? Yes, Maryann.

MS. O'SULLIVAN: In the main body of the paper on page 25, MediCal is discussed, and the date is very old. And what I'd like, even if this is going to be an attachment, for that to be updated. And also for there to be some inclusion in the first part about the fact that millions of California MediCal consumers are being moved right now into managed care and that the data in the body goes back to '93 data from Rick Brown. I'm sure DHS can easily give us the information.

DR. ENTHOVEN: Right now we're working on the findings section which is what the --

MS. O'SULLIVAN: My request there then is in the findings section there be a discussion of the fact that millions of MediCal beneficiaries are being moved to managed care.

MR. PEREZ: Mr. Chairman, couldn't we do that as either a separate sentence in here or a parenthetical statement following the numbers that are referred to with an asterisk indicating that some of the more current information may be found in the appendix?

MS. O'SULLIVAN: I just want an acknowledgement up front that this is a MediCal issue.

DR. ENTHOVEN: Did you have a particular place?

MR. LEE: I suggest on page 3, paragraph -- under "purchasers," there's a mention of how much money is spent on MediCal, to insert a sentence that you will do a fabulous job with noting there's been a rapid growth and a continued growth in MediCal managed care enrollment.

DR. ENTHOVEN: Where do I put --

MR. LEE: Footnote two, someplace around there. We know how much it costs in terms of the general costs of MediCal, but note in there in addition that MediCal is moving increasingly towards provided services through managed care vehicles.

MS. FINBERG: And indicate something about the numbers, three point something million.

MS. SINGH: Is there an objection to that technical amendment?

MS. FARBER: Could you restate it?

DR. ENTHOVEN: On page 3 in the paragraph that's headed "purchasers," it looks like the second paragraph there. Most of the way down we have: "During the same year, the total health care expenditures by California employ" -- no. Is that the right place?

MS. SINGH: Right after footnote --

DR. ENTHOVEN: Okay.

> "In 1994, government sponsored programs such as MediCare and MediCal accounted for about 41 percent of California's total health care expenditures of 105.3 billion. MediCal is moving increasing numbers of members to managed care with some illustrative numbers."

I believe we can do that getting the latest figures from DHS.

MS. FARBER: Thank you.

DR. ENTHOVEN: Other discussion?

All in favor of adopting the first eight pages raise your right hand.

(Complies.)

MS. SINGH: The section is adopted.

MR. LEE: 11 minutes.

MS. SINGH: Any opposed?

(Complies.)

DR. ENTHOVEN: Now, quality access cost. Agenda V D.

MR. LEE: This is section V D.

DR. ENTHOVEN: And the findings are just three pages.

MS. SINGH: So page one through three.

DR. ENTHOVEN: We have two speakers on this paper, Catherine Dodd of the American Nurse's Association of California. I want to emphasize that each speaker has three minutes, which I must really enforce.

Ms. Dodd.

MS. DODD: Catherine Dodd, American Nurse's Association of California. I just want to kind of challenge the concept that the documents as there's been dramatic change in quality been measured since we've had an increase in managed care in California. Because we have done research on the quality of hospital care, specifically the resulting downsizing and replacement of registered nurses with unlicensed personnel in acute care facilities, has occurred largely since the managed care penetration in California has increased so quickly.

Research was done looking retrospectively with OSHPD data at 295 hospitals in California at pneumonia, nosocomulus (phonetic) infections, pressure sores, post-op infections and falls, and it was discovered that in fact as managed care replaced registered nurses with unlicensed personnel, the skill mix went down in order to meet cost demands. The incidents of all those

adverse reactions to being hospitalized increased.

So to say that managed care has not had a qualitative impact; it hasn't had all the big indicators, but when you're sick enough to be in the hospital, it's made a big difference. Thank you.

DR. ENTHOVEN: May I just ask a question, which is, have you been able to tease apart what share of this problem is attributable to MediCare and the DRG system, what part of this has been attributable to MediCal and the selective provider contracting and the negotiated rates with hospitals versus --

MS. DODD: The data that was examined for the 295 California hospitals was between 1992 and 1994; so the DRG system had long since been implemented. So I don't think you can attribute that decline to the DRGs.

In terms of MediCal and selection, that was not looked at. We only had the OSHPD data to deal with which included skill mix length of stay, initial diagnosis, and untoward results when you are in an inpatient situation.

DR. ENTHOVEN: Thank you very much.

We will next hear from Beth Capell, Health Access, impact on quality access cost.

MS. CAPELL: Hello, Mr. Chair and members.

We have very substantial concerns with this paper in its current form. We have provided detailed comments to the members of the panel. We find that the paper -- the findings rely heavily on studies paid for by

the American Association of Health Plans. We also find that the papers' internally contradictory and contradicts other task force papers.

We would ask that if the choice today is to vote it up or vote it down, that it be voted down. However, we would recommend there be an attempt to rewrite this, if that's not the rule of the task force, we defer to that. I'd be happy to provide examples of internally contradictory and confusing statements. We provided those in some detail to respond to questions.

DR. ENTHOVEN: Thank you.

Discussion? This is just on the findings section.

MS. BOWNE: On page 2 on the first paragraph under Roman numeral III, I think we would be better served in the next to the last line to use something other than pharmaceuticals, such as prevention and health promotion. The reason for this is that outpatient drugs are not a MediCare covered benefit, and that's where you're picking up the differences there.

DR. ENTHOVEN: Exactly where are you?

MS. BOWNE: Page 2, Roman numeral III within the first paragraph, the next to the last line, "such as." My suggestion would be that you put in there "such as health prevention and promotion" or "prevention and health promotion," something of that nature.

The author is misplacing the fact that outpatient drugs are not a covered benefit under the

MediCare program. If you look back into the text you'll get my rationale on this. So there has been a misstatement here that pharmaceuticals are not typically covered benefits in unmanaged products.

When you are not referring to the MediCare market, pharmaceuticals are typically a covered benefit in unmanaged products. The reason that this got off-course is the author or authors were confusing MediCare covered services. So, in other words, all you need to do to correct it is just say "such as." Because pharmaceuticals are covered under unmanaged products.

MR. LEE: We'll just take that as a technical amendment without objection.

DR. ENTHOVEN: Except I think that the fact is that HMOs -- in addition to others -- doesn't purport to be the whole story. But HMOs, in fact, are bringing pharmaceutical coverage into range for many into affordability for many people in California.

MS. BOWNE: Excuse me, Alain. You're confusing, I believe, the MediCare covered benefits with regular health plans. The reason that a MediCare risk product includes pharmaceuticals is because they have to return the difference between what is collected from the 95 percent of the A.A.P.C and what it cost them to provide the benefit.

Among the noncovered MediCare benefits, are outpatients drugs. It's obviously a highly desirable benefit, and it entices membership. So you're confusing a

MediCare population with an overall population. In MediCare risk, if you want to insert under MediCare risk, then this would be accurate. Because the 10 plans -- the options under MediCare, since it's not a covered service that has to be in effect an additional service.

DR. ENTHOVEN: I'd be happy to put in under MediCare risk.

MS. BOWNE: You can do it either way, but it's inaccurate as it's so stated.

DR. ENTHOVEN: In addition --

MS. DECKER: Alain, I actually would advocate for going the other direction and I endorse what Rebecca said. In my experience, I've never found an employer's plan, unless it was a really small employer's plan, that didn't provide pharmaceuticals in just a PPO, in a fee for service. We've always covered it with deductibles. It's been there. So the HMO industry -- the innovation to me was much more in the preventive area than it was in pharmaceutical. It's only when it got to MediCare population that pharmaceuticals became the key.

MS. BOWNE: This isn't a do or die, Alain; this is just helping you reflect the market.

DR. NORTHWAY: The issue is that it's the wrong example. Just pick another example. I heard half of that.

DR. ENTHOVEN: That's fine. Thank you, Rebecca.

Any other discussion?

DR. ALPERT: This will seem nitpicky because it is actually.

DR. ENTHOVEN: Thank you.

DR. ALPERT: The reason I bring it up is because it's in the introduction. There are only three sentences in introductions, and people get a feel of a flavor or a theme for a paper. And since quality access and costs have been the buzz words for years now. I think there's a little bit of a theme that could be softened, and I guess I would offer this, as you referred to, as technical amendments. And it goes to the third sentence -- third and fourth where it says, "Much --

DR. ENTHOVEN: Which paragraph?

DR. ALPERT: Right at the beginning.

It says, "Much of this change has been good and necessary." Then it says, "change however is never comfortable for those who experience it."

First of all, that's blatantly inaccurate. I mean every doctor in the room, the day they finish their internship had massive change in their life and loved it.

(Laughter.)

So it's inaccurate.

DR. ENTHOVEN: You weren't scared when you had to go out and face the real world?

DR. ALPERT: More so, it seems like it's preaching rather than saying what's happened. There's been some change; there's been some change that's good, and sometimes change is uncomfortable for people who

experience it.

DR. ENTHOVEN: Just say, "some change has caused discomfort"?

DR. ALPERT: "Some change is good and necessary; change however is sometimes uncomfortable."

DR. ENTHOVEN: Okay.

DR. ALPERT: It's less preaching.

MR. PEREZ: You're changing both of those sentences.

DR. ALPERT: I did. I put, "some of the change has been good and necessary." I softened that and I softened the other. And it just presents the --

MS. SINGH: Is there any objection to those technical amendments?

DR. ENTHOVEN: "Some of the change has been good and necessary; change however is sometimes uncomfortable for those who experience it."

DR. KARPF: Could we combine the last sentence to nitpick a little more and just say, "Some perceive change as good and necessary; some perceive some of the changes as negative." It just balances it off. Then you don't have to say anything about changes.

DR. ENTHOVEN: "Some perceive these" -- you mean right after "good and necessary"?

MR. LEE: Right before.

DR. KARPF: "Some perceive these changes from managed care as being good and necessary; others perceive them -- and some perceive some changes as being

negative. And the change however is never comfortable for those who experience it" could just be deleted, since that's strictly an editorial statement.

MR. LEE: That's much better. It doesn't get in the judgment and conclusion. It introduces a perception --

DR. ENTHOVEN: The thing about comfort comes out all together?

MR. LEE: Right.

MR. ZATKIN: How would it read?

DR. ENTHOVEN: It would read as follows:

> "Early signs of managed care have existed in California for decades; however, managed care has grown faster and farther in recent years causing rapid change in the areas of quality access and cost. Some of this change has been good and necessary; some perceive these changes as negative."

MR. LEE: No. Perception and perception.

DR. KARPF: "Some perceive these changes as good and necessary and some will perceive some of these changes as negative."

DR. ENTHOVEN: I think it's obvious that some of this change has been good and necessary, like it's brought the costs under control. I think what you all are doing is pushing this back farther, and I wouldn't be surprised if some of my friends in the industry, with good reason, then said, "To hell with it, I'm going to vote

against the paper too." I'm just about at the stage of saying, "I got to vote against this paper."

I think that this is clearly, much of this change has been good and necessary, something to do to bring the costs under control. I can tell you this story about what was happening to us at Stanford or CalPERS or elsewhere.

MS. BOWNE: Would it be fair as long as it reflects both thoughts?

DR. ALPERT: What about going back to what I offered to begin with? "Some of the changes have been good and necessary; change however is sometimes uncomfortable for those who experience it."

MS. SINGH: Is there any objection with that technical amendment?

DR. ALPERT: I'm trying to avoid the theme that it's saying, "This is good for you, and you may not like it but you'll get used to it." That's preaching, and I don't think that's the intent of what you're trying to --

DR. ENTHOVEN: I think it's an evident fact that not everything has been good. We've heard a lot of bad things, but I think that the costs have been brought under control, accountability is brought in. So to say "some of this change has been good and necessary" is an obvious statement of fact. I'd rather lose the vote than back down on that sentence.

MR. PEREZ: As one of the votes you're going

to lose, I'd like to make a statement. I have a real problem with us being afraid to also say that some of the change has been negative.

MS. SKUBIK: It says that.

MR. PEREZ: The unwillingness to make equal statements about some perceiving the change --

DR. ENTHOVEN: But John --

MR. PEREZ: I'm just making my statement for the record, and I will continue to make my statement when I vote no on this. I'm just stating my opinion as others have stated theirs.

DR. ENTHOVEN: John, notice the last sentence.

MR. PEREZ: I noticed the statement; I'm just making my statement.

DR. ENTHOVEN: The last sentence says, "Some of the changes are caused by managed care are: parentheses "just as importantly perceived negative."

MR. PEREZ: The sequence like many other things is important to the way the things are read and the judgments that people take away from them. So I'm just stating my opinion. One opinion is not going to make a difference in terms of whether or not --

DR. KERR: What about the idea of dropping all the sentences and drop it after, "There have been rapid changes in quality access and cost." Get rid of the rest and then talk about what we found. Then we get around all this.

DR. ENTHOVEN: Good solution.

MS. SINGH: So the technical amendment would be to delete "much of this change has been good and necessary" delete "change however is never comfortable for those who experience." Delete "In addition, some of the changes caused by managed care are -- or as just importantly are perceived as negative."

DR. ENTHOVEN: We're just going to take out from "much of this change" to the end.

DR. ROMERO: Whole paragraph.

DR. ENTHOVEN: Okay.

MS. BOWNE: Call for the motion.

MS. SINGH: We need a motion.

MS. BOWNE: Motion to adopt the paper as amended.

MEMBER: Second.

DR. ENTHOVEN: Discussion.

MS. FINBERG: I have a general comment about the paper, which is I interpret the statutory direction to us differently then it's been interpreted or a decision made. I think that the request in legislation that we issue a report of the impact of managed care on quality access and cost goes to the heart of our mission and our findings and not directs us to have a staff paper on that issue. And although I do appreciate the efforts of staff, particularly in these various iterations to respond to some of the controversial issues around the paper, and I think it has improved, it does not effectively describe,

in my opinion, the full extent of the impact of managed care on quality access and cost from a consumer perspective. So I cannot, regardless of this wordsmithing, vote for such a paper.

MS. SINGH: Just as a clarification, we're just voting on the findings, not the paper.

MS. FINBERG: Well, the findings is what I would call the short paper.

MS. SINGH: Page 1 through 3.

MS. FINBERG: That's what I'm talking about.

DR. ENTHOVEN: Any other comments or discussion?

DR. ALPERT: I'd like to propose two deletions.

MS. SINGH: You have to amend the motion.

DR. ALPERT: I'd like to amend the motion.

Propose in deleting two words, the first word I propose deleting is in the bottom paragraph on page 1. In the next line of the bottom, it's the word "continuity."

MS. BOWNE: Are you at section two?

DR. ROMERO: Roman II last paragraph page 1.

DR. ALPERT: Continuity, it attributes continuity of care as being a quality enhancing activity associated with managed care, and I think that's an incredibly debatable issue at the present time. The other one I'd like -- I don't know if you want to do them separately or together. I can tell you the other one if

you want, then people can discuss that.

MS. FINBERG: Did you say delete?

DR. ALPERT: Delete the word, "continuity." Yes. What it's doing in this paragraph it's listing things that we are basically saying are quality enhancing activities associated with managed care. And continuity is -- I think it's debatable for me as to whether continuity of care has been improved massively.

MR. RODGERS: It is an enhancing activity of managed care to have continuity. It doesn't say that fee for service doesn't provide continuity.

MS. FARBER: The implication of it is exactly that.

THE COURT REPORTER: Please, if you can speak one at a time.

MS. SINGH: Members, if you could speak one at a time for the court reporter's sake. She's made that request to us.

DR. ALPERT: The second one on top of page 2, strike "rewarding quality" in the first one. And again for the same reason that I think that the rewarding of quality as being directly attributed to managed care -- I have trouble putting that in there in light of the paradox we identified that brought us to adopt the risk adjustment issue. The paradox was exactly the antithetical to rewarding quality care. There was a disincentive in the system to develop excellence in delivering good care to sick people and so forth. So I thought that's a big

enough paragraph.

DR. ENTHOVEN: I think this refers to systematic efforts in many managed care plans to measure quality in various ways and to have bonuses tied to that. We heard some examples, and there are many other examples in literature.

DR. ALPERT: I don't disagree there's a fluidity to this picture that we're looking at. It's just that since it's fluid and moving, this paper is kind of a reflection on what exists now, as I think it will be read. And hopefully these things will be able to be attributed to this in the future, maybe after the task force recommendations. But those are the two things I specifically identified.

MR. ZATKIN: What if we were to say at the beginning under "associated review" with the best aspects of managed care.

DR. ALPERT: Great.

MR. ZATKIN: Sort of emphasizing best practices.

MR. LEE: Several quality enhancing activities associated with the best practices of managed care, as the bottom paragraph of page 1.

MS. SINGH: Is there a second to that motion?

DR. KARPF: Second.

MS. FINBERG: So that means we add that in -- do we also add back in continuity?

DR. ALPERT: All these things are associated with the best practices of medicine period, however you deliver it. That's fine.

MS. SINGH: So the technical amendment for the record is: "Several quality enhancing activities are associated with the best practices of managed care"?

MS. DECKER: Are we changing the word "managing" to "managed"?

DR. ENTHOVEN: "Managed," yes.

MS. SINGH: That is the only technical amendment that's been moved?

DR. KARPF: Second.

DR. ENTHOVEN: Should we vote on that amendment?

MS. SINGH: Is there further discussion?

DR. ENTHOVEN: All in favor of the amendment --

MS. SINGH: -- raise your right hand.

DR. ENTHOVEN: Steve, do you want to vote for your amendment?

MR. ZATKIN: Yes.

(Complies.)

DR. ENTHOVEN: Any opposed?

(Complies.)

MS. SINGH: The amendment has been adopted.

DR. ENTHOVEN: Any other -- Dr. Northway.

DR. NORTHWAY: Alain, I thought last time as I recall this discussion about this paper, we were going

to put in some comment, I think fit best in the access area, that despite what's happened, maybe on the positive side we should realize that there are more people employed now than have ever been. Unemployment rates are as low as they have ever been, but the uninsured rates are rising. And that this may in fact have some bearing on the fact that managed care plans or cost of managed care plans or whatever else is going on to drive employers out of the health insurance coverage business.

DR. ENTHOVEN: I think there's good econometric evidence by independent studies and analysts that say that the big driving -- a very big driving factor in rising uninsurance is the rising cost. Two different studies said that the price elasticity was like minus .4; that is, if you have a 10 percent increase in premiums relative to wages you get a four percent reduction in the number people covered. So there's a lot of variables out there and --

DR. NORTHWAY: But we're talking about driving costs down, which theoretically seems to me should work the other way; that more people should be able to afford coverage, and that hasn't happened.

DR. ENTHOVEN: There's also perhaps a delayed reaction to increased costs.

Decker.

MS. DECKER: I think the issue that you're perhaps -- whoever the speaker was down there.

DR. ENTHOVEN: Dr. Northway.

MS. DECKER: Thank you.

Maybe the issue that you're trying to point out, which I think is a real one, is that because managed care has organized the delivery in a more restrictive manner, there's less charitable care or less ability of providers to provide care at reduced rates on an uninsured basis to people of low income. And I think there used to be a kind of gray market in health care where people that had no coverage could find providers that were willing to provide certain level of primary care at low rates. And that doesn't happen to the same extent anymore, at least that's my perception.

DR. ENTHOVEN: Are there data on declines in uncompensated care? I don't know. That's something that gets measures and reported, and I'm not sure that's done.

DR. KARPF: Whether there's cost shifting or not isn't an issue of managed care; it's an issue of decreasing reimbursement across the board. So I don't think we can blame that on managed care.

DR. ENTHOVEN: Thank you.

Maryann O'Sullivan.

MS. O'SULLIVAN: I want to thank the staff for moving the paper along to where it's been moved along. It's much improved over what it was, in my eyes. However, I agree with Jeanne's characterization. It's still not the consumer point of view. And also with her assessment -- I don't think this paper is a statutory requirement. I think we've answered the statutory

requirement because all through our recommendations we're responding to where things are in access cost and quality.

And I want to ask for a couple of changes on page 2. I'd like to delete the sentence "lower HMO premiums mean more people can afford coverage." Because even with the discussion you just had, I don't think there's anybody that has evidence that anyone who was uninsured because they couldn't afford to became able to afford to because costs went up less then they would have. That sentence could lead one to believe that people are insured now who were not insured before because now they can afford to get health insurance.

I want a motion to delete that. And also --

MS. SINGH: It's on page 2 under Roman numeral number III, footnote 11.

Is there a second?

DR. CONOM: Second.

MR. SKUBIK: Second sentence of Roman numeral III.

DR. ENTHOVEN: Maryann, the reason I will vote against your motion is because I think it has been well documented and good research by Lew and V.H.I. by professor Richard Krolak at U.C. San Diego; that there is a strong price elasticity of demand and that higher premiums cause more uninsurance.

MS. O'SULLIVAN: It may be that evidence looks like it might say that less people drop people, but I don't see it says that anybody goes out and buys

coverage and wouldn't have before.

MS. BOWNE: I'd like to speak to that issue. I think that there is ample evidence in the states that are embracing enrollment in HMOs through their Medicaid population, and they are therefore able to expand their Medicaid coverage because of the lower premiums.

Now, I'm not with an HMO company, but I think that Maryann there -- if state after state after state has embraced expanding their Medicaid coverage through a vehicle of enrolling their population in HMOs, whether one likes it or doesn't like it, that the lower premium offered through the HMO in a managed care construct has enabled many states to expand coverage to those who would not otherwise have had coverage.

MS. O'SULLIVAN: Those are two things that are happening at the same time, but I don't know anybody who's tied those together. The other two things that are happening is managed care is increasing and uninsured is increasing.

DR. KARPF: Oregon has actually lost people to managed care product, defined benefits to a certain degree and expanded its coverage in the state and minimized the number of uncovered people.

MS. FINBERG: They have also reduced the benefits, so it's not that simple. In fact, in California we have not found that to be the case in our MediCal program. So I think that's a very complicated issue, and it's hard to say in one sentence.

DR. ENTHOVEN: Okay. Let's just take a straw vote on the question. Lower HMO premiums mean more people can afford coverage.

How many oppose that?

MS. SINGH: I don't believe we can take a straw vote on this because it's been a formal vote. What we have to do is vote on it, but I think Dr. Conom wanted to also speak.

DR. ENTHOVEN: Dr. Conom.

DR. CONOM: I have to agree with Maryann, while this is a logical statement, I'd like to see it stricken because it basically -- the opposite has happened, while we may not know why. So as managed care has increased, so are the uninsured. They may not have anything to do with each other. I think this is a misleading statement unless we can show that more people have been able to afford coverage, and we can't really show that.

DR. ENTHOVEN: It's a multi-variant problem. I'm holding onto it because I think it's absolutely fundamental to the whole story. The main reason we need to get costs under control is so more people can afford to get coverage.

DR. CONOM: That has not happened.

DR. ENTHOVEN: That is because it's kinds of a complex and multi-variant problem in which we have, among other things, undocumented aliens and others coming into the state because we have various trends going on in

the structure of the job market.

But I think in the multi-variant research when they tease out the relationship between people covered and premiums, they get this very distinct, statistically significant price elasticity, and that's been done by two reputable researchers.

MS. BOWNE: There's some other people that want to speak to the issue.

DR. ENTHOVEN: Nancy.

MS. FARBER: I have the perception that there are more uninsured, and I think that's something that can be substantiated in real numbers in California. I think one of the things that's playing in the background in this question that you're discussing here, is the question of whether or not health benefits in the future will continue to be provided through employment. And you see employers backing away from that. You see employers specifically selecting the strategy of having per diems, rather than to pay for full time employees that have benefits.

Where Washington Township resides in the San Francisco Bay Area, we have a very explosive and volatile industry, the Silicon Valley. It's becoming to be a very dominant employer force in our township. And one of the biggest problems young people have, and these are middle class well-educated young people starting their families. And the biggest problems they have is in the course of one year they may be laid off two or three times and then go

back to work. And they go through large periods of time where they are not eligible for benefits and yet they are wage earning people. And I don't think managed care addresses that until you make benefits portable.

DR. ENTHOVEN: Thank you.

Rodriguez-Trias:

DR. RODRIGUEZ-TRIAS: This is just one article, but this is by authors from the agency for health care policy in research from Health Affairs and what they're arguing is that employment does not guarantee health insurance coverage. And recent studies show that employment base insurance coverage is falling so that there's a rising discrepancy between availability and people actually purchasing it because of their wage gap in relation to that and because of the rising employee contributions.

MS. FARBER: Yes. Thank you.

DR. ENTHOVEN: Tony.

MR. RODGERS: There is one case where because of managed care, if you will, population has been covered and that's the children. There's California kids, and that's a limited managed care product. And the only way that product would have been developed is under managed care format. But that's just one population. I just wanted to bring that up.

MS. O'SULLIVAN: It's only 10,000 kids. Less than one percent of the uninsured. It's nice but --

MR. RODGERS: It hasn't expanded beyond

that, maybe, but that is one population that managed care that make it affordable.

MR. LEE: This is somewhat falling on Ron's note to get us moving into recommendations is, I'm concerned about getting into discussions about each of these sentences. I think this in no way can be construed as an antimanaged care paper. I take strong exception, Alain, to your note that this has been all of a sudden transformed into something that I don't see it as.

I think the issue -- maybe I'll call it a question and note that if there's a no vote on this, as I understand it, this means this entire document is in Volume II. If that's the case, so be it. It's still part of the report and we can then move on to talk about recommendations. We're talking about three pages. Right now I think all we're talking about is Volume I or Volume II.

MS. SINGH: As just a point of clarification, right now we're talking about, there's a motion that's been seconded to delete lower HMO premiums meaning more people can afford coverage.

MR. LEE: But I called the question on that first so then I can call the question on the whole.

MS. SINGH: If you have someone that wants to continue discussion, in order to call the question, you need to have a two thirds vote.

MR. PEREZ: The question before us is the question of terminating debate. It requires two thirds

affirmative --

MS. SINGH: Those in favor of calling the question? The question has been called and he objects to that; so we need to have two thirds of the members vote in favor of calling the question and eliminating debate.

Those in favor of calling the question please signify by raising your right hand.

(Complies.)

The motion fails.

MR. KERR: Thank you.

I've listened to this discussion, and I find myself agreeing with both sides. It's true that affordability helps, but it's also true the positive thing didn't happen the way it's talked about. So if we can tweak it a little bit to not lose some of the concept but not push it away. What if we said, "lower HMO premiums keep coverage affordable for more people."

The idea of being if it had not kept it this way, the coverage had gone higher, more people who currently have it would have lost is likely because their employers would have dropped it. I think that's a very important concept. I think it gets us to something that actually has happened. It's a positive but it's not saying more people would have gotten.

Essentially, let's read it again: "Lower HMO premiums keep coverage affordable for more people."

DR. ENTHOVEN: I think that's a friendly --

MS. SINGH: Is there a second?

MS. O'SULLIVAN: That's fine with me.

MS. SINGH: Keep coverage.

MS. O'SULLIVAN: More affordable.

MS. SINGH: This is going to be a little complex. Is there any further discussion on this amendment?

MS. O'SULLIVAN: Deleting that line?

MS. SINGH: We have to actually go back and vote on that other one again.

MR. PEREZ: I want us to vote on that. I don't like that either.

MS. SINGH: Is there any other discussion on the Kerr amendment?

MR. PEREZ: I thought if you raised it as a technical amendment --

MS. SINGH: It's not a technical amendment. This is an amendment to an amendment. It's been moved.

MR. PEREZ: We're going to vote on the amendment to the amendment?

MS. SINGH: Actually it has to be seconded.

MS. DECKER: I'll second it.

MS. SINGH: Sorry members. We need to take a vote on the amendment to the amendment. Those in favor of adopting the Kerr amendment please -- does everybody know what it is?

MEMBERS: Yes.

MS. SINGH: Please signify by raising your right hand.

(Complies.)

The Kerr amendment has been adopted. And those opposed please raise your right hand.

(Complies.)

At this point what we need to do because this was an amendment to an amendment is we need to vote on the previous amendment which was Ms. O'Sullivan's amendment. So those supporting that amendment --

MEMBERS: It's amended.

MS. SINGH: Are we going to agree that that's been deleted and this is a substitution?

MR. LEE: Yes. That's what we just voted on.

MS. FINBERG: That's what we thought we voted on.

MR. LEE: And it had that same vote so can we take it as adopted?

MS. SINGH: So that has been adopted.

DR. ENTHOVEN: Maryann.

MS. O'SULLIVAN: Dr. Northway and Barbara Decker raised the question about what's the impact of managed care and uncompensated care and we thought we had no evidence. But on page 22 of this document there's a cite, a Health Affairs article, anyway, that discusses it. And I propose moving that paragraph up that's titled "uncompensated care" into the first three pages of the document -- page 22 of the same document. So to move that up into the section on -- it could be the second paragraph

maybe in the section on "impact on managed care access."

AUDIENCE MEMBER: That was a hypothesis; that's not an empirical study.

DR. ROMERO: That's a theory.

MR. PEREZ: It doesn't state it as --

MS. O'SULLIVAN: It's got a footnote.

MR. PEREZ: It doesn't state it as a fact; it makes a direct reference to an author suggesting --

MS. O'SULLIVAN: I think it moves important discussion. It gives an opportunity to flag that this is an issue that a lot of people on the task force thinks is important to look at.

MS. BOWNE: Second.

MS. SINGH: To move that paragraph to where?

MS. O'SULLIVAN: Page 2. It could be the second paragraph under Roman numeral III.

DR. ROMERO: To be clear, you're talking about copying it there not moving?

MS. O'SULLIVAN: Copying.

DR. ENTHOVEN: What's happening is we are making all these changes to accommodate people who are going to vote against the paper when we --

MR. PEREZ: You said you're going to vote against it too.

MS. SINGH: Is there any further discussion on that amendment?

DR. SPURLOCK: I have a little problem with something that's unquantifiable as altruism. It's very,

very speculative and really goes to the core of what many people went into medicine to do, is to be altruistic and to say that -- we can quantitate that and therefore it's important. We can speculate all we want about the altruism of the people who are practicing and delivering health care in our state and what their claim is, but it's different to say this is a finding of this task force. In my view, speculation is not a finding. I would not recommend to move it to the front of this section.

DR. ENTHOVEN: Dr. Northway.

DR. NORTHWAY: Maybe an alternative, try this language. On Roman numeral III, second paragraph: "Despite the lower overall cost generally, the number of uninsured continues to increase", then add the word "despite the lower portion of (inaudible), and the sentence goes on from there.

MEMBERS: Very good.

MS. SINGH: Is there any objection with substituting Dr. Northway's amendment with Ms. O'Sullivan's amendment?

MS. O'SULLIVAN: I do. It doesn't address uncompensated care. It says if there's more uninsured people, but it doesn't say anything about uncompensated care is going down the tubes.

MS. SINGH: At this point I would recommend we vote on Ms. O'Sullivan's amendment, and then it can be amended if appropriate by Dr. Northway's motion.

DR. ENTHOVEN: So those in favor of adopting

Maryann O'Sullivan's amendment please raise your right hand.

MR. LEE: As J.D. Just --

MR. PEREZ: No. Regardless of J.D.'s --

MS. SINGH: It's just Ms. O'Sullivan's. All we're doing is copying the uncompensated care section on page 22 and moving it to page 2 after the second paragraph under Roman numeral No. III.

MS. O'SULLIVAN: Remember, it was good enough for page 22.

(Laughter.)

MS. SINGH: Ms. Farber.

MS. FARBER: I have a question on how this vote works. We're going to vote on this amendment, but we could never vote on his amendment?

MS. SINGH: Yes, we can.

DR. ENTHOVEN: We are. They are separate questions. Now we'll take up --

MS. SINGH: No.

MS. O'SULLIVAN: I don't mind that as a friendly amendment to mine; I just didn't want it to substitute my language.

MS. SINGH: The motion has failed.

MR. PEREZ: You didn't finish calling the vote because you interrupted it to explain it.

MS. SINGH: I did. We'll do it again. Those in favor of adopting the amendment proposed by Ms. O'Sullivan to move uncompensated care -- copy

uncompensated care section to page 2, please raise your right hand.

(Complies.)

Nine in favor. Those opposed?

(Complies.)

11 opposed. The motion failed.

DR. ENTHOVEN: Now can we take up Dr. Northway?

MS. SINGH: He can now make a motion.

DR. NORTHWAY: I'd like to then move that it be modified, the second paragraph from the Roman numeral III to read as follows. This will be the first two sentences: "Despite lower overall costs generally" add, "the number of uninsured continues to increase."

MS. SINGH: As the number of uninsured continue to increase?

DR. NORTHWAY: Right.

"Despite the lower portion of total health care cost borne by consumers, some consumers," blah blah blah.

DR. ENTHOVEN: Discussion?

MS. SINGH: Is there discussion?

DR. ENTHOVEN: I have a comment.

Has anybody looked at, for example, Employee Benefit Research Institute Analyses of the current population survey? My impression is that the number of uninsured has been flat for about -- there was a big increase in the early 90s and then it became flat.

Does somebody really know or feel they could get their hands on something --

MS. BOWNE: I have that in a file in my office that I can look up whenever I get back there should this meeting ever end.

DR. RODRIGUEZ-TRIAS: Is that national data or California specific? Because California is real high in the proportion of uninsured.

DR. ENTHOVEN: I know it's high. The question is whether it's increased.

DR. RODRIGUEZ-TRIAS: At the beginning when we had that information on the structures and some of the overall penetration and so on, if I remember correctly, in two years' time there had been over one million increase in uninsured in California from six point something to seven point something million of uninsured people. So that's --

DR. ENTHOVEN: Ron?

MR. WILLIAMS: I think the data, actually check some data that we have a longitudinal survey that we've done over a long period of time. And I think the challenge is that California has a higher percentage of people who are uninsured than other locations. Our data shows that the number is flat.

As I recall, the Rick Brown study, it was a study that tended to look at 1994 data when the economy was pretty rocky. But what our data suggests is that it's fairly flat, but it's still a huge number of human beings

who are affected.

DR. NORTHWAY: Alain, I'll modify it to say the number of uninsured continues to be high.

DR. ENTHOVEN: Good.

MS. SINGH: Is there objection to that technical amendment?

DR. ENTHOVEN: I'd like to ask for a vote on that. All in favor of Dr. Northway's amendment, please raise your right hand.

(Complies.)

MS. SINGH: Those opposed?

(Complies.)

The amendment is adopted.

DR. ENTHOVEN: Can we now vote on the findings?

MR. LEE: I have one comment which is given where I think we are with the full report. One of the things we talked about at a number of meetings is the importance of framing why we're here. We talked about that being in the report in the context of consumers' perceptions and what is happening that brought us to the table. I think that's dropped off Volume I, if I'm not mistaken, about where we are with having a public perception or consumer vision.

I think this is a much better paper, but without a context in volume one that says that the changes that have happened are having huge ripple effects for consumers, I'm going to vote against this and have it go

in Volume II, which I think the public perception paper is going to go.

Part of the reason I'm concerned about this paper, I think it's a pretty balanced and much better paper. Right now its industry trends introduces this whole Volume I and this paper and not a perspective of what's happening to consumers as presented to us today and as we had discussions about it and all the testimony we received.

Correct me if I'm wrong in terms of process, but there will be a public perception paper as part of volume one, but in the absence of that we need to have voted on and considered, I need to vote against this paper and --

DR. ROMERO: Why wouldn't it be in volume one? Did I miss something?

MR. LEE: We would have to be voting on it. I'm not sure when it's going to be --

MS. SINGH: December 12. The public perception and experiences paper will be prepared for task force member review on December 12 and most likely adoption on the 13th.

MR. LEE: So we're going to have on the 12th a paper with both findings, some abbreviated portion and then an extended portion. And that's going to come from what sources?

DR. ROMERO: Our survey plus a substantial literature review of other surveys.

MS. SKUBIK: I'm sorry that that's not done already but correcting the data for our original research on our survey has proven to be a very painful process. As you heard this morning, we still have 300 interviews that need to be conducted before we get the data finalized before I can write it up.

DR. ENTHOVEN: John.

MR. PEREZ: I have about four pages of nitpicky amendments which I think would take us the balance of the day to vote down, because I don't think there's a majority vote for any of the ones I'd like to recommend. And I think there's several other people in the room who also have significant problems with this paper, but not a majority of the folks in the room. In the interest of time, I would like to call the main question, let it pass or fail.

DR. ENTHOVEN: No objection? All right.

MR. KERR: We are going to have the public perception paper.

DR. ENTHOVEN: We are going to have the public perception paper.

MR. KERR: So it will be given equal --

DR. ENTHOVEN: Yes.

MR. PEREZ: Again, obviously if the question isn't called, I'll make all 16 pages of amendments I have.

DR. ENTHOVEN: We're going to have a motion. I think John's right; it's time to vote.

MS. SINGH: Without objection, I think we're

asking members, those in favor of adopting the findings as amended, all the findings, please signify by raising your right hand.

(Complies.)

16 in support. Those opposed?

(Complies.)

Eight opposed. The findings are adopted.

DR. ENTHOVEN: Let's take a five-minute break.

MR. ZATKIN: Alain, what's up next?

DR. ENTHOVEN: Physician incentives.

(Recess.)

DR. ENTHOVEN: I apologize for the delay here. We have a lot of comings and going and people floating around and hard choices to make about which to do, but Phil and I have kind of concluded to do the least worst under the circumstances. We regret that John Ramey is not here at the moment, but we hope he will be back before long.

We're going to start with members of the general public who want to speak about choice of plan.

MS. BOWNE: Choice.

DR. ENTHOVEN: We're going to do choice of plan because --

MS. SINGH: Tab V C as revised.

MS. BOWNE: What is the date of the version we are working with?

MS. SINGH: Members, what you need to do is

work off of the findings and recommendations section that was provided to you in your manila folder.

DR. RODRIGUEZ-TRIAS: It says revised.

MS. BOWNE: Is the date November 18?

MS. SINGH: It may be on that paper. I have November 3, November 4, and November 18.

MR. LEE: The cover says November 21; attachment says November 18.

DR. ENTHOVEN: Just because I'm confused is not a reason for you to be confused. We will start with Conni Barker. This is on the question of choice of plan. I'd like each person to limit him or herself to three minutes or less. Thank you.

Ms. Barker, California Psychiatric Association.

MS. BARKER: Thank you, Mr. Chairman. Conni Barker, California Psychiatric Association. We gave you written comments that your staff distributed this morning. I'd kind of like to give you integrated comments on this and the other papers so you only have to hear me once. I'm sure you'd appreciate that a lot. For the most part --

DR. ENTHOVEN: Please just stick to choice and then come back on the other ones.

MS. BARKER: Okay. The one comment I had on choice, I'm a little puzzled. When I spoke to your staff they indicated that the information on the doctor/patient relationship which was in "principles" was going to go

into recommendations and findings; I guess that was a misunderstanding? That's what I wanted to talk about.

DR. ENTHOVEN: We are talking about adoption and expanding of consumer choice. And if things have been moving around, we are in a fluid situation. We're trying to balance the comings and goings of task force members. I apologize for that. These are not infallible, engraved in marble pronouncements; they are guidelines.

MS. BARKER: Where I became puzzled is the expanding consumer choice paper has also with it the principles, and that was my understanding they were going to go into the findings and recommendations.

MR. LEE: That's correct.

MS. BARKER: So I wanted to talk about the doctor/patient relationship that was supposed to go in there but isn't in there.

MR. LEE: The principles under Roman numeral I of expanding consumer choice is a section on a number of principles related to choices of health plans, choice is required to, and a list of things. Is that what you're referring to?

MS. BARKER: Correct. On page 5 of the one I got previously, but I don't see it in today's handout.

MR. LEE: There is no page 5.

MS. BARKER: I wanted to make a simple point.

MR. LEE: What's the point?

MS. BARKER: The doctor/patient relationship

discussion there doesn't talk about continuity of care if a doctor is removed from a panel. It is talked about in the other papers. I think it would be real good to cross reference the physician/patient relationship in that section so that continuity of care is always mentioned under A and B under --

MR. LEE: I think staff can take that as a constructive suggestion for page 5 of the background paper.

DR. ENTHOVEN: Next is Maureen O'Haren, California Association of Health Plans.

MS. O'HAREN: Thank you, Mr. Chairman, members of the task force. I think I'm going to focus on two issues, one in the recommendations of the paper and the other in the appendix dealing with some of the possible amendments to the paper. I think the biggest concern that we have with the recommendations is the one regarding the participation requirements. Participation requirements are imposed by plans in order to prevent adverse selection in the small group market. If you have two or three health plans offered by a very small group and one of those health plans, for example, happens to be a PPO with a wider network or of course coverage of any provider outside the network, you're going to get adversely selected against by individuals who have a strong relationship with the physician. And so that is why health plans impose these participation requirements.

It's not meant to preclude choices, it's

just one of those things that as a matter of resisting a plan must do. And some of the items in here that are intended to sort of moderate the effects will not work in terms of -- one of the examples, I think, was allowing the plans to increase the premiums. That just means you get the death spiral because the healthier people will opt out.

Risk adjustment while it's been something talked about in order to cure that kind of situation, I don't think we can foresee, especially in the near future, if at all, a small employer having the wherewithal and the technology to do risk adjustment.

The other issue that I wanted to address, I'll mention quickly that the potential amendment suggest amending SP 1559 to allow brokers and agents to own purchasing alliances. And I think the language in Michael Shapiro's memo which adds some suggested language is a good comment on why that probably is not a good idea. We did spend a lot of time debating that issue.

But the other issue, potential amendments that I really wanted to address is very important is the one that would effectively require every HMO to be a point of service plan. In other words, every HMO would have to provide some sort of coverage to members who wanted to leave the HMO. So what you would have, essentially, is every HMO would be a point of service plan, and that would effectively eliminate that choice from the market place, which I think is contrary to the purpose of this paper.

There are millions and millions of people who every year select closed panel HMO even when they have other options. And they do this year after year even if they don't have to pay additional premium because they want that choice. And I think that to preclude that choice to require every HMO to be a point of service plan, not only do you increase premiums off the bat, but you remove that one option.

For example, Kaiser is a closed panel HMO. They have been in business for more than 50 years, and people who have had options to choose other HMOs they have wider networks have continued to choose Kaiser every year both the benefit and of course the lower premium, if that's the case. We have strong concerns about that potential amendment.

DR. ENTHOVEN: Thank you very much.

Next we have Richard Figueroa from the Senate Insurance Committee staff on expanding consumer choice.

MR. FIGUEROA: Yes, Dr. Enthoven. First I do want to mention, Dr. Enthoven, we have the EBR most recent data in our office, if you still want that data.

DR. ENTHOVEN: Well, we modified the wording to get around it.

MR. FIGUEROA: I just want to take a couple minutes to make some comments about the choice paper, although choice seems to be one of the centerpieces what a task force should accomplish. There seems to be a less

than desirable amount of options in here in terms of implementation at the state level.

Michael Shapiro, an ex officio member proposed a number of recommendations that were on the table since the last meeting, yet in the revised findings and recommendations while some minor technical changes were made from that paper, we have not seen revised appendix that reflects a little more balance between the pros and cons, as well as the actual recommendations themselves in the body of the paper.

The two major focuses of Mr. Shapiro's recommendations, which I support, is expanding the market rules 51 to 100 employee size market. There is data both in this document as well as the University of California which show there is discrimination against employers in this market, and certainly you're not going to see the expansion of purchasing groups in the 51 to 100 markets unless there are market rules.

In the small group market there are market rules, the HIPC can exist. You're not going to expand purchasing group in the 51 to 100 market unless there are market rules that level the playing field between insurers in that market. Both the California small business association and some insurers, consumer groups, provider groups and other consumer groups support the market. Without these, certainly any kind of HIPC expansion of this market (inaudible) pretty dramatically. Again, if you want to expand purchasing group in this market, pretty

much got to do a plus offer towards expanded choice.

The other issue of course is in the individual market. The individual market is completely unregulated. Individuals have a major problem in getting choice in that market, particularly those that are perceived to have adverse medical conditions, and they end up going in for high risk pool, which is a very limited benefit package.

Now, certainly, I as well as most people recognize that just offering coverage on demand result in very bad adverse selections. So what you see here in this recommendation is when you establish market rules, you do it with a lot of mitigating issues to kind of reduce the amount of risk selection that you have in that market, including limited open enrollment periods, use of preexisting exclusions, prohibition against switching between high and low deductible plans on demand, tenure discounts, even doing things such as premium rating and larger risk adjustment processes that spread the risks much more evenly across the marketplace. We have done extensive work on what other states have done.

DR. ENTHOVEN: Thank you very much.

MR. FIGUEROA: I'd like to talk about that as well which is why there are mitigating factors. Take a look at other states.

DR. ENTHOVEN: Thank you very much, Mr. Figueroa.

Next we'll here from Jeanette Morrow,

California Coalition of Nurse Practitioners. She's got two items. Would you please speak right now to the item, which is consumer choice of health plans.

MS. MORROW: Thank you.

I have just a comment and actually it's a compliment regarding the change in the language from physician/patient to provider/patient, which is a benefit to nurse practitioners, and it's very difficult when we are constantly butting up against barriers because of language which excludes us by using terms that don't include us.

So there's a lot of confusion in the Knox-Keene Act that says that patients must be assigned to a primary care physician. Nurse practitioners provide primary care; can we be called primary care providers?

So the semantics in language that says physician, even though we don't want to see it expanded into a lot of verbiage saying other providers within their scope of practice, we do need to address the issue in a way that affords us conclusion. So I would commend the committee on making that change.

DR. ENTHOVEN: Thank you very much.

MS. O'SULLIVAN: Dr. Enthoven, on that question, I think last time we committed to doing that, but it didn't show up in all the papers. We were going to move from saying doctor to say health care provider or health care professional.

DR. ENTHOVEN: The manual of style that Sara

issued and came across my e-mail and everybody else's told us to do that but unfortunately we don't have the electronic technology that allows you to put it in once and for all. So the intent and the pretty good compliance has been to do that. And if you think that it could be done better, come on down and help me with the typing.

MS. O'SULLIVAN: So by the end we'll try to do that?

DR. ENTHOVEN: Yes. These things are cycling so fast.

MS. O'SULLIVAN: Thank you.

DR. ENTHOVEN: Thank you very much.

Anne Eowan, Association of California Life and Health Insurance Company on the consumer choice paper.

MS. EOWAN: Thank you, Mr. Chairman and members. I'm Anne Eowan with the Association of California Life and Health Insurance Companies. For those of you who are not familiar with my association, we represent PPOs and some HMOs as well.

I have a couple of comments, particularly with regards to what appears to be a second recommendation in the paper on the minimum participation requirements. The concern that our association has is that it's presented in the paper as if it's a form of skimming to have participation requirements. I actually was a part of, as a number of other folks in this room were part of, the small group reforms that set up the participation requirements.

The concern that we have is that any health plan, even though you do have some mitigating language in here where you wouldn't have to do both an HMO and PPO -- the two plans aren't the same -- even two HMOs or even two PPOs, what happens is that an employer group will say one to ten, you'll have one employee in that group who may want additional benefits. And even if you have something that's similar, maybe another health plan has something that's more friendly with regards to say fertility coverage, which is something that's kind of popular in the news, that employee would ask for a different health plan. That health plan would not be able to refuse guarantee issue. They would get that employee and only that employee not be able to spread the risk among the entire group, and then when that employee determined that he or she no longer needed the services, the next enrollment period they can opt out.

The reason you have participation requirement is less in terms of skimming but more to protect in terms of risk selection.

I would say if you have an aggregate minimum participation requirement of 80 percent for a group, just because the entire group 80 percent is covered, if you have that one who's picked you because they want to use the services, the 80 percent doesn't help you to avoid adverse risk.

So I think there's some assumptions in that recommendation that would actually lead to less choice

because those plans that provide a little bit more choice will be eventually selected out of the marketplace because they have to guarantee issue. So I would ask you seriously review that recommendation.

Quickly in terms of the appendix, I'm not clear quite how the appendix is going to be used. There are additional recommendations in appendix format that our association has been on record for a number of years with concerns. And I'm going to quickly go through this, Mr. Chairman and members.

We are very concerned of course with amending the market rules, the 51 to 100 market. There's been extensive debate on this. I'm not sure that this poor task force has so much in front of them, would have the benefit of all that debate, but our concern is that the employer groups in that market are not asking for the change, primarily because they are able to negotiate their own benefit plans right now.

And what happens when you do guarantee issue or guarantee renewal like you did in the small group market, what happens is that you have to just -- because you couldn't possibly guarantee 1,000 plans -- narrow down your choices. And those employers that are currently in that market and some of them are large enough to self-insure purchasers will self-insure.

DR. ENTHOVEN: Thank you very much.

MR. ZATKIN: Mr. Chairman, may I ask a question.

DR. ENTHOVEN: Sure.

MR. ZATKIN: Back to the participation requirements. Suppose it were structured so that it involved basically a split, offering dual choice so that a carrier couldn't have more than a 50 percent requirement -- could have a 50 percent requirement.

Would that work in your --

MS. EOWAN: You mean in terms of it has to be 50/50 between two health plans? That's something to consider. I don't know if you got a two live group, whether that really helps you because it goes down to --

MR. ZATKIN: Let's say a group of six.

MS. EOWAN: Really I guess it just depends on how -- I think there are some mitigation in here in terms of --

MR. ZAREMBERG: Mr. Chair, maybe I can respond to Steve. I think it's a practical situation. Consider yourself, you're an employer with 12 people. You go out and you offer your employees two plans, but you say as a caveat, "I can only offer you two plans if no more than six sign up on each plan." Then you have to come back and say, "Well, I couldn't get six in one, so everybody has to switch to another plan. It's really unpractical when you say only 50/50.

MR. ZATKIN: It doesn't obligate the employer, as I understand the recommendation. It obligates the carrier if the employer wanted to.

MS. EOWAN: That concern about gaining with

particular employees.

MR. ZATKIN: I don't think it obligates the employer.

MR. ZAREMBERG: The plan. But they work together. I don't know how you distinguish one from the other. When you go up from -- I don't quite understand. You're still stuck with the same problem, Steve.

DR. ENTHOVEN: We have some more questions, Dr. Northway.

DR. NORTHWAY: This morning we heard that there's a fair amount of discontent among the people in California, some of the people in California that are covered by various and sundry plans. It seems to me the fewer the number of choices that they have, the greater the number of complaints. And that's an issue that obviously we're going to grapple with. It's an issue that the state will eventually have to grapple with, but yet you're saying in the market place the reality is you can't offer a lot of choices.

Can you give us some ideas as to how we can deal with this so in fact the people of this state feel comfortable about plans that they are being offered.

MS. EOWAN: Employers currently, there are a number of health plans that offer a dual choice arrangement, same health plan but they offer a POS with an HMO option so the employer can choose something like that. The employer can go right now to the HIPC and get a choice of more than 10 plans. So I mean there's choice in the

marketplace.

DR. NORTHWAY: Not in the 51 to 100.

MS. EOWAN: 51 to 100 they can negotiate their own benefit package. In the debate that we unfortunately don't have time to do today on that issue, those few small employers that were not able to get a choice of 10 plans were always able to get at least one or two. They don't have the same problem as the small group market and they're weighing against removing choice for 98 percent of the folks who are happy with that marketplace to affect the two percent that may have problems. And we've been working with Gallegos and some of the other members and Senator Rosenthal trying to figure out if there's some way absent to guarantee issue in that market so you can try and affect some of that.

For example, maybe you allow small employers who are in the small employer market to stay in their small employer market if they get to be say 51, 52, 53 life groups. Maybe we don't allow them to redline by industry. So there are other options that aren't explored in this paper. And I know -- I don't want to -- I know you are all being very patient with me, but I think before the task force adopts recommendations that are very far-reaching and have been the course of debate in the capitol, that there are a number of issues on all of those -- and I haven't even got to the individual coverage of course. You might want to wait in terms of that because I think it's a little premature. I think you

deserve that debate.

MR. ZAREMBERG: Dr. Northway, the chamber -- this falls into that category of 51 to 100 employees. We have three HMOs where it would offer -- in fact, we can negotiate price, and many of them have participation requirements and were able to negotiate those with the health plans too. So you do have -- when you're in a 51 to 100 category, you do have the ability to enter into the marketplace and develop plans that each of the employees needs today.

DR. NORTHWAY: All we're saying is whether we should put a little teeth in that so in fact everyone in the 51 to 100 market offers three plans. Because apparently the people of this state are saying, the more plans I have to choose from, the less problems I have with the system, if I heard the data correctly.

MR. ZAREMBERG: Dr. Northway, let me submit to you that when the debate was going on with AB 1672 in the small group market reforms, the allegations were made; some people said you're crying wolf, that there would be fewer PPO options for the individuals in the small group market.

And lo and behold that's exactly what happened. You look at the HIPC, and there's really no viable PPO in the HIPC. But it was worth the trade-off because at that time you couldn't buy affordable health insurance in that small group market. Now you can whether you're in the HIPC or outside the HIPC. It was worth the

trade-off. Since I don't think there's really anyone that expects rates to go down and accessibility will improve significantly.

I think if you go back and look at that data today, would you want to be the one to promote less PPOs in the marketplace for everybody in that 51 to 100 category? And that's exactly what you would do if you were guaranteed -- you do this small group reforms for the 51 to 100 marketplace. That's the consequences of it. Whether you think that's good or bad, those are the consequences.

DR. NORTHWAY: I'm not going to argue. I'm just responding to what I heard from somebody who supposedly did a nonbias report; like 42 percent of the people that they surveyed were unhappy. And the people who were the most unhappy were the people who had the least choice. That's going to eventually end up on Martin's desk to say, "Assemblyman, do something about it."

MR. ZAREMBERG: What I'm saying, Dr. Northway, on the proposal for the 51 to 100, the bottom line is you will give them fewer choices of types of plans if you adopt the small group market reforms 51 to 100.

MEMBER: Which turns the argument on its head. I'll wait to be recognized later, but I think we're getting into another discussion instead --

DR. ENTHOVEN: I'd like to move this on now

to the paper. I'm sorry. We have Beth Capell. Beth Capell from Health Access on the consumer choice paper.

MS. CAPELL: Thank you.

Two points, not to enter into the discussion at length, but we are generally supportive of the suggestions made by the staff to the senate insurance committee with regard to the individual market and the market for employers 50 to 100, in hopes that more people will have access in that market.

We would ask the task force in its deliberations on another recommendation, the recommendation on changing ERISA to consider very carefully the implications. We support broader consumer choice. We are, however, troubled by the notion that without an employer mandate to provide coverage, that we would require employers to do certain specific -- to offer a variety of choice. We believe that there are employers for whom this would be challenging; those are not the large employers. And I think your data reflects that smaller employers have difficulty now offering a range of choice. We wish the task force in its deliberations to consider carefully the impact on access.

DR. ENTHOVEN: May I ask a question please?

MS. CAPELL: Yes.

DR. ENTHOVEN: In 1973 the Congress passed the HMO Act requiring every employer of 25 or more -- essentially what it came down to is offer to HMOs as well as your fee for service plan. Now, I have to admit I kind

of lived the experience, but I haven't seen good documentation or anything.

Did that cause a lot of employers to drop health insurance or did it bring down small business or did it cause other negative consequences on its way to opening up the marketplace HMOs?

MS. CAPELL: I'm sorry. My recollection, I don't know the data. And my recollection of the health care market in California does not extend back to 1993 and I apologize for that. My sense of it is that we see declining employer participation; that is, we know that we have fewer than 50 percent of all Californians now have employment based coverage. This is an area of great concern for us and we just -- we tread cautiously in the area of requiring employers to offer multiple choices if it would mean that more Californians would have no coverage at all.

DR. ENTHOVEN: Thank you.

MS. BOWNE: And, Alain, employers under 25 were --

DR. ENTHOVEN: I said 25 or above.

MS. DECKER: Can I make a comment. I almost can remember back then almost.

DR. ENTHOVEN: You were in high school.

MS. DECKER: The issue, I think an HMO Act was that it was required that if you were mandated as an employer, and I may be not be remembering the terminology correctly.

MEMBER: Triggered.

DR. ENTHOVEN: I can tell you with great precision, I just used a shorthand because I assumed everybody knew the full story. That was, the law said if you're an employer of 25 or above, subject to the Fair Labor Standards Act and if a group practice HMO and if an individual practice HMO served employees living in your area and if they came to you and triggered the mandate, then you had to offer them.

MS. DECKER: I think from my rememberance of the large employer market, we all came up with strategies to demonstrate that we had not been appropriately mandated, so we didn't have to offer.

(Laughter.)

DR. ENTHOVEN: That really reinforces my faith in employer infallibility, doesn't it? So we will remember that when we consider arguments about how wise and all knowing employers are.

MS. DECKER: It was mainly an administrative thing. We didn't want to have to support it.

MS. BOWNE: Neither do small employers.

DR. ENTHOVEN: I think it's time for us to move to the paper to the findings and recommendations. We placed in your file because of all the confusion of all the foots and takes, Sara kindly stayed up the night before last and made a new, clean copy that, as we said, they tried to correct several problems, like we had it right in the back, but hadn't transferred it into the

front. Then we reviewed suggestions from some members that were in the nature of technical corrections or questions of fact or something, not substantive or policy changes, and thought it would be simpler for you to work off of that. If you don't want to do that, you have the paper that was sent out to you, that version, and you could work from that, either one. The new paper which is meant merely as a courtesy and convenience to you, is in your manila folder. We need to go to the page 3, task force recommendations.

Michael.

DR. KARPF: Alain, before we get down to the specifics, could I ask a question relating to a philosophical approach concerning the letter I wrote to you?

As I thought about how we were defining choice in this paper, and it's a very important approach. It's one of trying to simulate competition to drive down price and improved quality. Certainly that's an important public need and certainly an important benefit for consumers.

As I thought about choice as an individual, as a consumer, as I thought about choice for other consumers, my concern was when consumers think about choice, they might not necessarily think about choice between two similar types of plans, two very restrictive HMOs, but actually think about choice in terms of will they have access to a particular provider or particular

center of excellence at a time of need.

And in fact the data we saw today makes me think about that even more. Because we saw this morning that someplace around 75 percent of Californians had concerns about their ability to choose a provider of a provider that they wanted or a center of excellence and were willing to pay something for it. Now whether they are willing to pay enough, that's something that's debatable. But it really does lead to a different issue.

And as a more -- as a broader interpretation of choice, and I would wonder if we are going to deal with that or we're not going to deal with that or if anyone else on that task force has an interest in dealing with that?

DR. ENTHOVEN: I think we need to reduce it to some kind of specific proposal that we can deal with.

DR. KARPF: I think that one can develop proposals that would suggest that point of service or tiered managed care products be mandatorily offered if not imposed.

DR. ENTHOVEN: I E-mailed you. We've corresponded about this. I'm trying to think what did I send back. Have you been reading my E-mails?

DR. KARPF: I've only been reading the reports. I haven't got to my e-mails

DR. ENTHOVEN: That's too bad. I did think about what you said and I wrote you some long E-mails. Here's some ways we can do it. I tried to come up with

some fairly tangible suggestion to you that you might like to come back with a specific report.

DR. KARPF: I would go through the trouble if there was interest in it. I suspect there may be some interest in it, but I think it will take some thinking and some crafting. But I would like to have some sense of is that on the table or is that not on the table?

DR. NORTHWAY: I think it's extremely important.

MR. KERR: I do too.

DR. NORTHWAY: The first part.

DR. ROMERO: I've been following some of the traffic, although not all of this. And I who knew nothing about this issue a month ago, my reaction is this is a very interesting and looks like a very productive idea, but requires a lot of work to develop it and cost it out.

So one approach to get the camel's nose under the tent would be not to recommend a mandate on something that is not fully developed, but to recommend a study or further work by the regulator working in consultation with the industry to basically do a feasibility study over the next six months or a year.

This is not an attempt on my part to water it down because I like what I've heard. I like what I heard a lot, but I've only heard enough to say to me this is worth further study, not that it's baked yet.

MR. ZATKIN: Could I ask a question? I'd like to know what the definition of the problem is.

Because point of service is pretty widely available. So tell me what the definition of the problem is.

DR. ENTHOVEN: Any employer in California can buy a point of service.

MR. ZATKIN: That's correct. And if the question is any employee, that's an issue of the employer's willingness, which is really an ERISA issue. In terms of California, what's the definition of problem?

MS. FINBERG: What percentage of people have a plan with a point of service option in the state?

MEMBERS: Can you speak louder.

MS. FINBERG: I was asking a question what percentage of people in the state have a plan with a point of service option.

MR. WILLIAMS: Anyone who is covered by any of the major health plans in California would have an option down to groups as small as two of either an HMO or a PPO or HMO and point of service. I know we carry it. Pacific Care has it. Blue Shield has it. Health Net has it. I think that the prevalence in the marketplace is to offer -- that the most health plans offer a choice of HMO, POS or HMO, PPO, and sometimes all three.

MS. SINGER: We received data from KPMG on that. I think it's eight percent have the point of service plan and another 23 percent have PPO.

MR. PEREZ: Mr. Chairman, I would have liked to move this at this point, except I have one problem with it. If we can resolve the problem, I think we can move

forward quickly. That's regarding the recommendations to change ERISA. I feel strongly that if we required employers to offer multiple choices, what in fact is going to happen we will have less choice because many employers will be priced out by having to offer multiple options. I can't support that, and before we actually have a motion on the table, I wanted to raise that problem, and I think others in the room might share my concern.

DR. ENTHOVEN: Barbara Decker.

MS. DECKER: I would like to ask for clarification from John. When you say "priced out," are you saying that it would cost the employer too much administratively to provide multiple option?

MR. PEREZ: Yes.

DR. ROMERO: Just stop offering coverage?

MR. PEREZ: Offering coverage all together.

MS. DECKER: I actually think the pressure will be more like, "I will go to an ERISA type basis for offering my coverage, and then I don't have to comply with whatever state requirements there are." So I agree, people may react in different ways, but I think you get more ERISA plans if we mandated something on a state basis, get more people going that route to escape.

DR. ENTHOVEN: John, I now regret that we didn't find a way to research it. What was the impact of HMO activity in 1973?

MR. PEREZ: In 1973 I was a little too young to follow the HMO Act.

MS. BOWNE: But, Alain, I think even if you had researched it, you would come up with a mixed bag. I think there have been a number of studies done, many of which have been published in Health Affairs that talk about why employers do or don't offer any health plan or multiple health plans. And over and over again the number one barrier in the small group market is cost and the fact that the employer knows that once they give that benefit to their employees, they can't take it away. So they are afraid to even offer it because their viability and their long term economics are not stable enough. So that's the number one reason in the small group market.

In the larger group market they do tend more to offer health benefits, and I think that's been proven by EBR, anything you want to look at. And in fact employers are offering -- more of them are offering health plans now, according to our latest Health Affairs study. It's increased in 1987 from 78.7 percent to 1996, 82 percent of employers are offering health benefits. Clearly that is very weighted to much more in the large group, much less in the small group.

But this artificial imposition of saying that all employers that offer have to offer multiple choice isn't going to work until we have either an employer mandate or some other structural change. And this recommendation is quite frankly going to lead to fewer PPO options and fewer choices in the health benefits market. And I realize it was well-intentioned, but it

unfortunately is either premature or dead wrong. I'm not sure which.

DR. ENTHOVEN: I keep coming back -- I don't think all those bad consequences occurred in 1973 although --

MS. BOWNE: I was the Kaiser lobbyist. I negotiated those things, and I can tell you it did more damage to the HMO movement, and that's why we do not see it today. Because employers resent being forced to offer something. Many offer it; many employees love it, but not everybody wants it and you can't jam it down their throats.

MR. ZATKIN: Rebecca, remember we never triggered that.

MS. BOWNE: That's correct, Kaiser never triggered anything.

MS. SKUBIK: Kaiser's position has always been you want to be in a market where you have choice.

MS. BOWNE: That's right. That's because they have a closed panel and they want to be sure that where you elect an option of a closed panel, you in addition have the option of other choices. And, I believe, at least as far as I remembered with Kaiser, they were always offered alongside another benefit plan.

Today the market is somewhat different. Because most of the big players are offering double, triple, quadruple options, an employer can go with -- I'll just call it plan X and offer the whole potpourri of

choices, and as we see, the market has evolved that we no longer need or have or in some people's mind desire the benefit trigger that you have to offer an HMO. Why would we in 1996 want to come back in and say you have to offer?

DR. KARPF: '97.

DR. ENTHOVEN: It's because we have this evidence that says some large number of people especially in the small group area do not have a choice of plan and because --

MS. BOWNE: There are more that don't have any plan rather than don't have a choice. You're going to have more that don't have any plan that have a choice if you implement this.

DR. ENTHOVEN: Ron Williams.

MR. WILLIAMS: Thank you, Alain.

I think that the challenge for all of us is the challenge of what I call counter-intended consequences. That we all want to increase choice and yet the very actions that we take often result in decreasing choice. That we all want people to have more access to health care, particularly at the individual level, and yet the very actions we take can end up in reducing the access at the individual level for health care.

I think in terms of mandates and requirements, the question that I would start with is that a mandate is at the end of the policy spectrum, in my mind, and that we would need to have pretty compelling evidence that the market in competition and the fact that

health plans and others who see the kind of data that we saw today -- although I view that as preliminary and I'd be very interested in seeing the full study -- won't respond to what messages they are getting from consumers about what they are interested in and the messages they are getting from employers.

The fact that individuals don't have choice isn't a function of the fact that health plans don't offer choice; it's a financial determination on the part of the individual employer. So if it's available but they won't buy it, mandating that they buy it won't necessarily result in them buying it anyway. I think that's a little bit about my point of view.

DR. ENTHOVEN: Clark.

MR. KERR: I've only heard hearsay so I'm not sure how true this is. I think if employers realize that what they are doing when they give one choice is doubling the dissatisfaction rate of their employees. That would be something to be interested in. I've heard the rumor anyway that brokers get more commissions by making sure only one plan is offered, and so that the employer who's say you're 30 or 40 employees or 100 employees, you're so damn busy, you can't think about health care. And if the broker is getting more money to tell you, take this one plan, they tend to believe the broker, regardless of whether the employer -- certainly not the employee's standpoint.

There's also another issue that yes, if you

do offer several different plans, some of them like POS and some will be more responsive. Nobody is requiring the employer to offer health insurance, and certainly nobody is requiring them -- what amount of money they put in. They can put a set contribution in, give us a choice and let the employees pay the difference depending on which plan; so it doesn't affect the employer, per say.

So it's the employees, and a few of them, not all. Obviously the majority said they wanted it but wouldn't pay enough. If they want to pay enough, at least they have the option. If the employer is still putting in $50 or $75 bucks, regardless if they choose the $75 buck plan, the difference is --

MR. WILLIAMS: That's what happens today. If our products between 2 and 50, there's not a small employer where each employee does not have a choice of an HMO or a PPO literally, each and every one. And yet the employee for economic reasons and the employer who often sets the contribution in a way that guides people in the direction of lowest cost option. So I get the sense we're trying to address an economic question, at the same time we're struggling with the kind of choice consumers want.

MR. KERR: The statistics we've seen in the paper here and certainly the ones we saw -- seem to indicate that there are a fair number of employees who even when you include the spouse plan still don't have a choice. And it ranges somewhere, it's a little bit below 50 percent but not much. It certainly affects a lot of

the people in the hundred and below market. I guess maybe you guys offer all this choice, but then the reality is it's not getting there.

MR. WILLIAMS: I don't mean to hold this out as totally unique. I know lots of my competitors do the exact same thing.

DR. ENTHOVEN: I wonder if the data report -- you're offering -- you have kind of a single --

MR. WILLIAMS: Mix and match.

DR. ENTHOVEN: I wonder if it's all Blue Cross but you can have Blue Cross PPO or Blue Cross -- I wonder if that in the data gets reported as a single plan.

MR. WILLIAMS: That's why I said I would be very interested.

MS. DECKER: If people don't know what plan they're in, maybe they don't know they have a choice of another plan.

MR. WILLIAMS: I think it's an economic question.

DR. ENTHOVEN: John.

MR. PEREZ: I've already gone once. If you want to go to people that haven't gone.

DR. ENTHOVEN: Bill, go ahead.

MR. HAUCK: Barbara made the point I was going to make. Data shows people don't know what they're buying anyway. They don't know if they are buying a PPO or an HMO or a POS, XYZ.

MR. ZAREMBERG: I'm calling on that for

different initiatives. People in PPOs think they're in fee for service medicine. That's their perception.

DR. ENTHOVEN: Nancy Farber.

MS. FARBER: No.

DR. ENTHOVEN: Alpert.

DR. ALPERT: Not to confuse it a little more but I thought we were talking about two different things. Michael and Phil started sort of one thing and then we get off on this. And I thought initially they were totally separate and now I'm not so sure.

I don't know if it's appropriate or not to hear from them a little bit more about -- as I understand what they're talking about is to try to do something to give the choice at the time when most people need the choice. Is that what you're saying? I.e, it's not necessarily at this juncture that we're talking about now, but you're trying to -- this came up briefly at the last meeting -- to try to explore something at a time when somebody would want to opt out, for instance if they had a life threatening -- when something is really a problem.

DR. ROMERO: I'm reacting to things I've heard. I'm not an advocate for this position. Let me tell you as I understand it. Michael, you can elaborate.

The idea that I was reacting to, as I understood it, was mandatory POS with some high deductible so that the employees were responsible for a substantial amount of first dollar coverage. But then they have the option of going out of the network, exercising their POS

above that level -- and if necessary, for some specified list of diseases.

Again, all that was not meant to advocate. That's just the way I interpreted it as I heard discussion.

MR. ZATKIN: You mean exclusive -- when you say mandatory POS, you mean exclusive POS? You mean that's the only product --

MR. ROMERO: No. I want to stress, I'm not the author of this idea. There's a limit how far I can go. As I've understood through the discussions I've heard, it would be -- there would be a mandate to offer POS as one of several options, to offer what I just described as one of several options.

MR. ZATKIN: Mandate on --

DR. ROMERO: You've reached the limit of my -- that's as far as I can go.

DR. ENTHOVEN: Shapiro.

MR. SHAPIRO: I'd like to put this in the broader context in terms of the task force deliberations. The legislature has often been accused of micromanaging managed care. I think there's some fundamental papers, an issue for this task force, and I command the Chair, in particular, that deal with market reforms, to make the market work. And one of the fundamental things you can do to make the market work is provide choice among the plans.

I happen to think that putting the ERISA option the first option as a practical matter is

interesting, but I think the chairman himself personally got brushed off by Shalala last night because the practical matter -- I don't see that happening in Congress because of resistance of the employer groups and labor groups and others. It actually is clean; the sky did not fall in 1973 when that happened, and there was choice. It's no longer there.

DR. ENTHOVEN: What a humiliation to be blown off by Donna Shalala.

(Laughter.)

MEMBER: I commend your persistence because you came back.

MR. SHAPIRO: In terms of whether there's a problem which was Steve's point, you got UC Davis UCLA data saying discrimination -- and obviously in the individual market but at the mid-size market level. We're seeing discrimination there. I took exception to the paper that said, "Insurance industry and small business propose this concept." Small business association which is the mid-size folks, not the Chamber of Commerce support reforms in the mid-size market. There are some --

MR. ZAREMBERG: They also supported employer mandate. It was voted down by the -- California small business association supports an employer mandate not the general --

MR. SHAPIRO: And I do not.

MR. ZAREMBERG: Several of our members have fewer than 50 employees, so I truly resent that. I think

it was an overstatement.

MR. SHAPIRO: My point is this: There is a problem in the market. Choice is one way to deal with that market problem. And finally there are ways to do it with mitigation to limit ERISA switch ERISA and others, and you have to balance the benefits of choice, whether it's mid-size, further reforms in small group or individual against the risks that people fear in terms of reducing options employers switching to ERISA. And no one has suggested that balance is not there and those risks are not there.

I think the only question is whether this group wants to choose promoting choice knowing those risks versus not promoting choice and saying the risks are too great. And I think that's the question. I'm not saying those risks aren't there. We've tried to mitigate them. If they are not adequately mitigated in the minds of those who are concerned, the vote is no; the risk is too great. And the risk may be less in the mid-size market than it is in the individual market, and you can take it different ways.

But choice, we've seen the stats. You don't have choice, you're less pleased with the system, the market is not working. It's a market macro issue and I bring it to you in that context.

DR. ENTHOVEN: Thank you. Phil, did you have --

DR. ROMERO: Yeah, thank you Alain.

Just two bits of information about the public's preferences from our preliminary survey. First, not from our survey but from our literature review, I want to just reinforce a point Clark made earlier that my read is that surveys where people ask about your level of dissatisfaction and then compare those with those respondents who have choices and those who don't, the without choice, your dissatisfaction tends to be about half again or double that.

Our survey when asked whether people would favor or oppose a -- "workers pay some additional money for insurance that would allow them to pick any doctor they wanted," and I'm abbreviating this, but this was made clear that it was not mandatory, that it was voluntary, 70 percent favored that idea. When people were asked how much they would be willing to pay for a plan that allowed you to pick any doctor you wanted, the median number was about $25 to $30 a month. My only point -- and I'm not an --

MS. BOWNE: That would not cover the cost, and I would further submit to you I think we need to do some segregation of the data by if the only choice of plan is a PPO, that is freedom of choice, you just have to have the economics to go out of network.

MR. PEREZ: If I may, I think we're talking about things and we're taking information from the survey and we're not taking it in the proper context. We're talking about choice versus no choice. And there's really

a third thing we ought to compare it to. It should be choice, no choice, and no coverage.

MS. BOWNE: Yes.

MR. PEREZ: And I would venture to say that people with coverage but no choice are a little happier and a little better off than people with no coverage.

DR. ROMERO: Yes.

MR. PEREZ: If I could just read a sentence here. We've been very careful about not making unrealistic mandates to either the legislature, the governor, or employers. If the phrase before us was, "the task force recommends that the U.S. Congress create a new law like the provisions of the original HMO Act that requires employers to offer choice of plans which may be satisfied by purchasing through a purchasing group or modify ERISA to allow California to do so," we would vote against it. But because it says that this is only limited to those employers that currently offer coverage, we seem to be more willing to make that mandate. And I think that's an unreasonable mandate.

I think it's unreasonable for us to put a higher burden on employers who are trying to do the right thing right now by offering some health care coverage to their employees. And for us to force those employers to offer multiple choice is really, in my opinion, going to move us in the wrong direction and move people from no choice to no coverage. And I think that it's really wrong of us to do that.

MR. KERR: If you don't require the employer to pay any more money, if the additional money for that comes from the employees and it's their choice yes or no, the employers really are not that unhappy about the idea of having fewer dissatisfied employees. Believe me that's the not the case.

If the employee is given the choice and is going to pick up the tab and the employer -- having come from the employer's standpoint -- is concerned about the cost issue; it doesn't impact them; the only thing it can do is leave a few fewer dissatisfied employees.

MR. PEREZ: I don't agree with the assumptions built into that argument. Because I think the costs are not just the costs that are going to be borne by employees. I think they are administrative costs that will be borne by the employer that may even increase the copayment that employees would have to pay for the plan that was originally offered to them which I don't think will increase employee satisfaction; that they have to pay more money to get the plan that was already offered to them or pay more money still for a new plan.

MR. ZAREMBERG: I couldn't agree with John more. I couldn't say it better myself. I think there's something important, another point that Phil brought up about this point of service, and we've used the survey to say people want choice.

One of the things that was also in the survey, and I've talked about we want to make sure people

have PPOs to choose from. I think they also said they like the staff model HMOs. They know what they are buying when they buy staff model HMO. They know exactly what they are getting when they get a staff model HMO. And it isn't a question of point of service. They know it's a closed panel and they know what they are getting.

So whenever we say people are more satisfied when they have choice or with a point of service, the data also shows when they know what they are purchasing and they choose the staff model HMO they are satisfied. So to say we ought to insert additional requirements on everybody that cost everybody more money and may reduce the access to health coverage, I'm not sure.

I just want to make that point. Let me summarize why because then I won't talk anymore. I agree with what John says, and I think Beth supported that too. We both share the same concern. We may not agree on a lot of things, but we agree employers should be able to provide access to health insurance as much as possible, and when you raise the costs and especially in the small insurer market, small employer market, you're going to reduce access.

I think that the participation requirement when you eliminate that, it's also going to raise costs in the small group market. And once again that elasticity is going to reduce the access to health insurance.

Can I ask a formal question, a procedural question? Because when we drafted up the plan -- we have

this process of if it's in the paper, then we have to have a vote to take it out. Does this mean everybody has to vote to take one and two out if we disagree before we approve the plan?

MR. LEE: Since I'm next in line, if I could, in terms of the process, before something has been put forward as a motion, we can reword it or move it as the recommendation. And one thing I would encourage us to do is follow through recommendation by recommendation add or delete.

In terms of that, relative to -- I think this background discussion is very important. I'm concerned that the hard issues around choice, we have been talking a lot about ones we can have much less impact on. There's other hard issues around choice of access to specialists, et cetera, where the rubber hits the road for most consumers that we aren't going to have time to talk to in the context of doctor/patient relationship, practice of medicine, and I hope we do get to talk to. That's a note in terms of us being able to be more rigorous with our time. I think we really need to have a timekeeper to remind us what we're taking away in our later discussions because we're doing that and --

MS. SINGH: It's been almost an hour.

DR. ENTHOVEN: I think it's time for us to take a vote on the first recommendation.

MR. LEE: I'd like to propose a dramatic change in the first recommendation and see how this flies.

MS. SINGH: We'll do a straw poll.

MR. LEE: This is a straw poll. Then we can decide if it's going to be moved. But the language would be: "The task force recommends to the U.S. Congress to consider changes in law like those provisions in the original HMO Act to require or provide incentives to employers to offer a choice of plans."

And then I'd note in parentheses, "This choice may be satisfied through purchasing through a purchasing group and this may require modification to ERISA to allow California to do such actions."

And it goes on, "such actions should consider the need or the desire to expand coverage as well as expand choice amongst plans."

MR. PEREZ: Mr. Chairman, may I offer an alternative for consideration in the straw poll? That another consideration that we might have before us would be the language without any reference to mandating the choices and without any reference to the changes to ERISA. So if we just took out the language that we spent the last half hour arguing about, maybe if we take a straw poll on that as well.

MEMBERS: What's the language you're suggesting?

MR. LEE: That's what I tried to do. It said to consider either mandates or incentives. Either way you can try to -- I think the point that I'm trying to

make is --

MR. PEREZ: I think what I'm basically saying is get rid of A-1, the first paragraph immediately below A and everything including No. 1 and maybe even some stuff after that. But I know that I feel strongly that I could not support any of the language that we just went over, and I think there are several other people in the room that also have that same concern. And instead of us trying to tweak it, let's just figure out if there's really a consensus that we don't want to have this kind of reference. And if we don't, then we can figure out how to read the language to agree with the sense of the room.

MS. DECKER: But what's left?

MR. PEREZ: I don't know what's left.

MS. SINGH: Members, point of clarification here. Mr. Lee has made a technical change. I think that we need to have a straw vote on his change, and then we can move on. Because it's going to be complex and unfair to other members if we amend things that are not --

MR. PEREZ: If we're taking a straw vote.

MS. SINGH: I think we need to take a straw vote on his first.

DR. ENTHOVEN: Let's take one on his because his is a way of sweetening this pill, and then we will say whether people are willing to swallow the sweetened one.

MS. SINGH: It doesn't mean that it's adopted.

MR. PEREZ: I understand. If you give

people alternatives, we're talking about giving people choice; let's give people a choice. Do you like Peter Lee's alternative or do you like not having any reference to ERISA in the --

DR. ENTHOVEN: We will vote on Peter's because Peter's might sweeten the pill enough that some others may be willing to swallow it. Let's have a straw vote on Peter's sweetened wording which basically says to consider changes in the law and require or provide incentives to employers to choice of plan and consider the desirability to expand coverage.

MS. DECKER: Is that directed to the U.S. Congress?

MS. SINGH: Yes. It would read -- I believe it would still continue to say, "The task force recommends that the U.S. Congress consider a change in law like ERISA."

MR. LEE: I think it would probably be -- I would suggest to -- with all due respect, Alain, to pull out the (inaudible) provision HMO Act. And part of the intent -- and I'd also be happy to say task force recommends Congress and the state legislature consider changes in law to require or provide incentives to employers to offer a choice of plans.

MR. PEREZ: I have a question, specifically on your recommendation. Is this requirement or incentive still only applicable to those employers who currently offer coverage?

MR. LEE: No. I specifically dropped out "that offer coverage."

MR. PEREZ: So what you're saying is theoretically we could be asking for a mandate for all employers to offer multiple coverage?

MR. LEE: Potentially. The consideration -- the point was made, which I think is a very good point, without mandated coverage some folks would drop out. I don't know that I support that. But it's either mandates or incentives to try to get more employers covering more people.

MS. SINGH: Shall we take a straw vote?

DR. ENTHOVEN: All in favor of Peter's amendment please raise your right hand.

(Complies.)

Seven.

Now, all in favor of John Perez dropping.

MR. PEREZ: We're trying to get a sense so we know how to tweak the wording.

MEMBER: So is yours to strike this?

MR. PEREZ: Mine is basically to strike any reference to ERISA in creating these mandates that employers who currently cover people offer more choices.

DR. ENTHOVEN: So all in favor of striking everything between "a" and "establish" that whole section.

MS. SINGH: Could you please raise your hands high. I only count 16. That's a straw vote only. So the majority has indicated their preference to delete

"A"; so perhaps somebody should make a motion to amend a recommendation --

DR. RODRIGUEZ-TRIAS: Not all of "A," just between --

MS. SINGH: "A" and "1."

DR. RODRIGUEZ-TRIAS: It's A-1.

DR. ENTHOVEN: The next one is --

MS. SINGH: We haven't made a motion. Will someone make that motion.

MR. PEREZ: I move that we strike the language immediately following "A" up until and including "California to do so."

DR. SPURLOCK: Second.

MS. SINGH: Discussion?

DR. NORTHWAY: If you do this, which probably we're going to do, there needs to be some preamble in the first couple pages to explain that despite the fact that the survey we took said the choice is really important, that there are some consequences to this that we're concerned about if we go ahead and change this law. So it doesn't look like we took this survey and then just totally ignored what the survey said.

DR. ENTHOVEN: We'll rework the language to fit with the recommendations.

MS. SINGH: Any further discussion?

MR. ZATKIN: It seems to me the choice of plan remains a solid objective; that the problematic aspect is mandating the employer to provide it. I think

Peter was onto something when he talked about incentives. It seems to me Congress is in a better position to deal with that than us which is why we're so frustrated. It would be appropriate to express the sense of the group, if that is the sense, that a choice of plan is desirable and that Congress should explore ways of achieving that without getting into -- without endorsing an employer mandate -- I mean there are three ways I can think of; one is to allow the employee in a group to opt out, like a voucher to get a choice; there are some administrative issues but you can do that. Another way would be some kind of an obligation on the plans to offer point of service. I'm not endorsing that, but -- then the employer route. But expressing the view that choice of plan is desirable without getting into the mandate may have some --

MR. PEREZ: Mr. Chairman, might I suggest that the easiest way to do that would be to first of all vote in favor of the motion before us which strikes the language which many of us find objectionable, and after we do that, we can create an amendment to insert language which isn't objectionable and that expresses the sense you're conveying, Steve.

MS. SINGH: Dr. Rodriguez, did you have a comment?

DR. RODRIGUEZ-TRIAS: Just a quick comment. I'm in favor of taking the focus of U.S. Congress and as we craft the new language to concentrate on what we want

done at state level.

DR. ENTHOVEN: Let's get this piece of business behind us.

MS. SINGH: Those in favor of deleting recommendation A-1.

MS. DECKER: Goes in the interim --

MR. LEE: As stated.

MS. SINGH: As stated, please raise your right hand.

(Complies.)

Those opposed?

(Complies.)

The amendment is adopted. Recommendation A-1 has been deleted.

DR. ENTHOVEN: Peter.

MR. LEE: Not wanting to give over deference to the president's commission, they punted on this in a relatively graceful way that I suggest we steal language. I think it's important we acknowledge this issue and we can make a broad statement without going so far as to make a mandate requirement.

Could I read a two-sentence language, which I suggest we pull and put in here as our first recommendation, which is:

> "Consumer choice of health plans is important and should be provided whenever possible and in a way that is affordable both to employers and consumers."

That's sort of --

"Small employers should be provided with greater assistance in offering their workers and their families a choice of health plans and products."

Assistance without saying what the form of that assistance is.

DR. RODRIGUEZ-TRIAS: Without stating anything --

DR. KARPF: I would hate to leave here without doing something to push the issue of choice. Since this thing has been essentially gutted, would we be willing to consider asking the government legislature to appoint a task force to develop --

(Laughter.)

It would be much more focused to develop broader approach to choice and access to citizens of California and to understand and maximize coverage for citizens of California. Otherwise we just walk away from the issue of choice completely.

MS. SEVERONI: Bite me, but I would support that. I really would. I would support that. I think it's too important to let it go. I think we avoided using this punting to --

DR. KARPF: We're making a lot of economic assumptions based on peoples biases, based on old data. We need some new information to really build an economic model that says what choice and access really do.

(Recess.)

DR. ENTHOVEN: Let us now go to recommendation two. This is a fairly complex thing that -- yes?

MS. O'SULLIVAN: Just sort of a process question. In the appendix of the previous expanding choice document, we had discussion about expanding the --

DR. ENTHOVEN: We're going to get to those.

MS. O'SULLIVAN: We are. We're going to get to the ones in the 50 to 100s?

DR. ENTHOVEN: If we just get back on track here, we'll get back to those. Because the faster we get to these, the sooner we will get to those.

So the second recommendation --

MEMBER: And if you believe that.

DR. ENTHOVEN: -- that the state prohibit health plans to small group market from setting minimum participation requirements for participation in their plans, thereby effectively declining to participate in multiple choice offerings by employers instead of an aggregate participation requirement for all plans offered -- all plans offered to be permitted to protect against adverse selection against the market as a whole. In other words, you can have an aggregate requirement of participation but not for individual plans.

This recommendation should only be implemented to the degree that negative consequences such

as increasing prices or skimming can be avoided. For example, it may not be appropriate to apply the recommendation cases or an employer --

MEMBER: Excuse me. I'm sorry. Please --

MR. LEE: He said that the text as presented is what's been --

DR. ENTHOVEN: Yeah. The text that's been presented, yeah, go ahead and read it, yeah.

DR. SPURLOCK: And so we don't need to read it each time.

DR. ENTHOVEN: The question I want to ask now is just a straw vote.

How many people are interested in discussing minimum participation?

MS. BOWNE: What's the alternative?

DR. ENTHOVEN: That we don't discuss it and move on to the next item.

MS. BOWNE: Then what would happen to it?

DR. ENTHOVEN: Then it would vanish.

(Laughing.)

DR. ENTHOVEN: Then we would turn it over to John Perez.

MS. RODRIGUEZ-TRIAS: He'll delete the whole thing.

MR. PEREZ: I'll replace it with some interesting language.

DR. ENTHOVEN: Where are we? Yes.

Dr. Northway.

DR. NORTHWAY: Isn't this more of the same? The issue is offering more choice could end up with people without coverage. And if it is, then you need to state that; but you need to say that choice is a problem. I mean, people want choice. But if we mandate things, it could end up with no coverage and that's worse than having somebody a little bit disgruntled because they only have one plan.

DR. ROMERO: Can I ask a question?

If you look at 2-B, the bottom of that page.

DR. NORTHWAY: Maybe you can tell me what 2-A means and then we --

DR. ROMERO: There's caveat language in 2-B. "Only implemented to the greater of the contract such as increasing prices," et cetera, "can be avoided." Do you find that?

DR. NORTHWAY: I don't think that deals with the issue of no coverage, does it?

DR. ROMERO: Well, I'm sorry --

DR. ENTHOVEN: What position -- does someone think -- where's Zaremberg?

Those in the back of the room, would you please resume your seat.

MS. BOWNE: Alain, I think this discussion would be enlightened so that everyone is aware of what the current federal law requires.

The federal law that was passed in 1996 requires all carriers who serve the small group market to

guarantee issue to all small employers all plans that are offered in the market. Further, once you go to an employer, you must take anyone and their dependents who elects coverage.

Now, the one protection in an extensive negotiation on this issue at the Congress was that the carrier may set a minimum participation threshold; however, the carrier must set it for the entire state. You know, because they are going to go through the state and determine -- let me give you the example.

If a carrier goes to a small employer and their minimum threshold is, you know, 25 percent, 40 percent, 50 percent, whatever, they can only take that group if the group elects to that minimum threshold. They cannot decide that for group A where I got the healthy ones, my minimum threshold is 25 percent; and for group B I want to make it 70 percent because, gee, I might get that one sick person. They have to set the same threshold.

Now, that mitigates against a carrier setting it too high because they know that they're not going to get everyone. It also mitigates against them if they are underwriting correctly from setting it very low because they want to get enough risks in the groups that they insure to spread those risks. But the federal law prohibits selectively taking a small group or not taking it or selectively taking an individual and/or their dependents; so the threshold has been set. The carrier

determines what their minimum threshold is, but it has to be applied uniformly.

DR. ENTHOVEN: I think the sense of this -- Rebecca, thank you very much for that explanation. You've helped me understand that better than I did.

The sense of this is to say, the minimum threshold should be applied to the total percent of the population group covered.

MS. BOWNE: But you can't do that because you have different groups coming on at the different months of the year or for different years. And I would defer to the business representatives here, but if I'm not mistaken, I think that most businesses rebid their business with different carriers almost every year and that may be -- you know, it's an economic decision on the part of the employer, but that also means that if they make an economic decision to switch from carrier A to carrier B and the physicians who were part of the network or whatever for carrier A or not in carrier B, that's when you get some "X'd" over the choice issues. It's the plan shopping which is an economic benefit to the employer may or may not be of an economic benefit to the employee, but it's a fact of life.

DR. ENTHOVEN: Well, what I'd like to do is just ascertain, does the task force want to go on discussing this issue? Is that --

MS. DECKER: With the option being not discuss it and drop it from the paper?

DR. ENTHOVEN: Yeah, right.

MS. FINBERG: Well, we'd like to vote on the recommendations.

DR. ENTHOVEN: Well, we're going to have kind of a straw vote on the recommendations.

DR. ENTHOVEN: This is going down to here (indicating.) Okay? This whole section (indicating.) From "establish" down to B on the next page.

I just want to give people the opportunity to say they're not interested, they don't want to go on discussing it. So may I have a show of hands on that. How many people --

DR. KARPF: Just one question.

DR. ENTHOVEN: Yeah?

DR. KARPF: Does that mean if we vote that we're not going to discuss it, this task force will never discuss it again? Should we come back later when we see the data that we asked for to find this a big central issue and feel that we haven't addressed it and feel bad about what we've done --

DR. ENTHOVEN: No.

DR. KARPF: -- if we would have read it?

DR. ENTHOVEN: No. For now, it's off the table, but I would like to be able to reserve the possibility of off-line interacting with task force members and seeing if we can find some Phoenix in these ashes --

DR. KARPF: Or if we ever catch up on time,

have a broader discussion on this.

DR. ENTHOVEN: Yeah. So just to try to move through these specifics pieces.

MR. PEREZ: I've got a question because I'm not -- if we were to vote not to discuss this right now, would it mean that this paper would have no recommendations at the end of this discussion?

DR. ENTHOVEN: Well, no, because there are --

MS. SINGH: It's a straw vote.

MR. PEREZ: So we're only going to section B on page 3 or B on page 4?

DR. ENTHOVEN: Then we run down to B on page 4, yeah.

MS. O'SULLIVAN: And you also said we're going to consider the 50 to 100?

DR. ENTHOVEN: Yeah. Then we're going to get -- then we're going to talk about those other ones.

MR. PEREZ: So -- because I'm still not clear. So we're talking about basically eliminating everything up to and including parenthetically small D?

DR. ENTHOVEN: Yes. Right.

MR. PEREZ: So that --

DR. CONOM: No. I thought it was all the way to capital D? We eliminated everything up to capital D.

DR. ENTHOVEN: That's what I'm saying. Then we will take a look at capital D.

All right. All -- the straw poll, those who just don't want to discuss this issue for --

MS. BOWNE: Why don't we take a vote on eliminating this recommendation.

DR. ENTHOVEN: All right. Make a motion?

MS. BOWNE: I'd like to make a motion that we eliminate recommendation No. 1.

MS. SINGH: Just for the record, the established rules regarding minimum participation requirement, that entire section?

DR. ENTHOVEN: All in favor --

MS. SINGH: We need a second.

DR. ENTHOVEN: Ron seconded it before Rebecca.

MS. O'SULLIVAN: John Ramey's not here. Who brought this? John Ramey did, right? He simply ought to be here to say why.

DR. ENTHOVEN: No. Actually --

MR. ZAREMBERG: Can I speak?

Mr. Ramey talked to me about participation requirements and we had the discussion, and he said that he agreed with me that it was inappropriate to put it in the paper which was about three weeks ago we had the discussion.

MR. KERR: How did it originally get in the paper?

DR. ENTHOVEN: Well, Sara and I did it because we were struggling -- at the last meeting Peter

Lee said that what we had was limp and we were just struggling in reaching for, is there anything we are going to totally strike out on this question of expanding choices? And we still got some other things to look at.

MS. BOWNE: We still have recommendation -- the last one.

DR. ENTHOVEN: We've got several more that have come in.

So let's take a vote.

MS. SINGH: With no further -- without further discussion?

DR. ENTHOVEN: Yes.

MS. SINGH: Those in favor of deleting established rules regarding minimum participation requirements, please indicate so by raising your right hand.

(Complies.)

MS. SINGH: Those opposed?

(Complies.)

MR. ZATKIN: How many votes?

MS. SINGH: It's been deleted by --

MR. ZATKIN: 16.

MS. SINGH: -- have voted to delete it.

DR. ENTHOVEN: All right. Now that brings us --

MR. PEREZ: I gave a courtesy vote, Steve.

MR. ZATKIN: That thing won't cost you.

DR. ENTHOVEN: The third one may meet with

Peter Lee's disapproval or meet his criteria also, but anyway, as another attack on it, is B-3 ways to expand purchasing groups? Take a look at that. I'd like discussion on that.

MS. SINGH: Is there a motion to adopt recommendation B-3?

MR. SHAPIRO: I see number three as somehow a sort of simplified variation of the appendix options which also deal with --so I just point out that the appendices deal with -- which may go up or down, that my substitute for this to compliment this, I urge consideration that these may be mutually exclusive or not necessary or there may not be any to demand, but to consider this last one in the context of the appendix recommendation.

MR. PEREZ: I have a question for Mr. Shapiro, actually. Are you suggesting, then, that we pull some of the things from the appendices and move them into this?

MR. SHAPIRO: Well, it was my understanding -- I refer to the chairman that we are going to get that later as a potential issue for consideration be folded into the paper. And the only thing I'm pointing out now is No. 3 which deals with facilitating purchasing groups very closely related to two of the recommendations in the appendices, and I'm just trying to make sure we are consistent within whatever we choose to do or not do and that you consider maybe discussing this one in the context

of the options in the appendices. I just don't know when you want to do that.

DR. ENTHOVEN: I was thinking of just taking them in order.

MR. SHAPIRO: That's fine. So the discussion will allow acknowledgement that if you endorse either mid-size reform or individual reform, you may not need to also want to endorse this or may supplement, but it's hard to take them.

MR. HAUCK: Mr. Chairman?

DR. ENTHOVEN: Yes.

MR. HAUCK: I would move we approve recommendation three.

MR. PEREZ: Second.

DR. ENTHOVEN: Discussion?

MR. ZAREMBERG: Call the questions.

MS. SINGH: Those in favor of adopting recommendation B-3, please signify by raising your right hand.

(Complies.)

MR. LEE: I do assume it will be renumbered?

MS. SINGH: The recommendation 24, those opposed?

(Complies.)

MS. SINGH: Okay. The motion is adopted. Recommendation three is adopted by 24 votes.

DR. SPURLOCK: Are we going to have a discussion about the language, the positive language about

endorsing choice and setting direction that Peter mentioned earlier? Didn't we ever have debate or have discussion on that?

MR. KERR: We're not giving you the choice.

DR. ENTHOVEN: Just in our little coccus over here trying to figure out how to revive this, we couldn't come up with anything that sounded more than sort of, I guess as Les said, an empty tent. I think it might be more productive to let some of us prochoicers go off-line and see if we can come back. If we sort of have general permission, at least we can have another run at it if we --

MR. KERR: This is actually prochoice, prolife comments?

DR. ENTHOVEN: If we've got something better, if we can come up with some better idea. Is that all right?

MS. RODRIGUEZ-TRIAS: Yeah. I think that's a good idea. I wanted to just make sure that we keep within that discussion Phil's suggestion earlier of a feasibility study, that that be one of the -- perhaps one of the recommendations that has some longevity.

DR. KARPF: Should we put it on the agenda so that it be discussed again and so that there be no question that's it's -- legitimate question we can discuss it again?

DR. ENTHOVEN: Feasibility study of --

MS. RODRIGUEZ-TRIAS: Of choice for the --

MEMBER: Can someone who will have very specific proposals --

MS. SINGH: Members, can we speak one at time because of the court reporter.

DR. ENTHOVEN: One at a time.

MS. SINGH: May I just ask a question? Members, are you interested in adopting the findings section of this choice paper now or would you prefer to do it when we come back to this paper?

DR. KARPF: When we come back.

MS. FINBERG: Well, I think we need to go to the alternative recommendations.

DR. ENTHOVEN: Yeah. We've still got --

MR. LEE: But regardless of the alternative recommendations, we're going to carry this over to the next meeting to hopefully have --

DR. KARPF: Or the December meeting.

DR. ENTHOVEN: We have received several new fairly late entries. We included these in an appendix to the draft paper called "Expanding Consumer Choice of Health Plan." The first one, the task force recommends that the legislature enact a guaranteed issue plan design disclosure and premium rating limitations for employers with the 51 to 100 employees so that purchasing cooperatives can form, flourish, and obtain a wide variety of participants in the mid-size market.

If this sounds a little arcane to you, the key point is that the HIPC needs -- for the HIPC to work

in the 2 to 50 size market, it has to have some protection from adverse selection by the small group rating bands which inhibit insurers from picking off the good risks so that only the bad risks go into the HIPC. And that so far has been the case, and so the small group reform laws match up with the HIPC size.

So if you're wondering what is the relationship here, the goal is to get more people into the HIPC or similar arrangements, and in order to do that, you've got to have more people come under the small group protection or -- since Michael sent it, Michael, is that an adequate explanation of your --

MR. SHAPIRO: That's very accurate. Thank you.

DR. KARPF: Mr. Chairman?

DR. ENTHOVEN: Yes.

DR. KARPF: Could I ask that all issues of choice be postponed to the next meeting rather than dealing with particulars, since I think we've choiced out at the moment?

MS. FINBERG: No. We were promised that we could discuss these because some of us feel that these are very critical to the choice issue. If we can't resolve them, then they may need to get deferred also.

DR. ENTHOVEN: Right. In our attempts to come back later, we have to get some guidance.

Do we want a motion on this?

DR. SPURLOCK: You were talking about

adverse selection in the HIPC. Are you talking about within the HIPC or outside of the HIPC --

DR. ENTHOVEN: No. Out --

DR. SPURLOCK: -- compared to outside of the HIPC?

DR. ENTHOVEN: HIPC -- yeah, compared to outside the HIPC.

DR. SPURLOCK: Because we had a discussion about risk adjustment within HIPC. And we're not talking about that?

DR. ENTHOVEN: No. We're talking about some hypothetical insurance company looking at the HIPC and saying, oh, there's pooling of risks there, and what we're going to do is figure out which are the best risk groups and we're going to go offer them a much lower better premium because they are better risks.

DR. SPURLOCK: Out of the reading limitations?

DR. ENTHOVEN: And pull them out of the HIPC.

MS. BOWNE: But Alain, that cannot be done according to existing law.

DR. ENTHOVEN: That's what I'm saying, Rebecca, is, that's my whole explanation, is the need existing law to inhibit that from happening.

So now the proposition is, is this to be raised up to the size 50 to 100? By the way, this is not my proposal. I'm going to try to facilitate this in a

neutral way.

DR. ROMERO: John Ramey who is one of the two members of the expert research group who put the choice paper together, along with Allan Zaremberg, is not here, of course. I talked to him on the phone earlier and he apologizes, but he stressed to me that of the five recommendations in this appendix, this is the one that he supported by far the most.

MS. SINGH: No. 1?

DR. ROMERO: No. 1. He supported this particular recommendation. He thought this was his crown jewel.

DR. ENTHOVEN: First question is, do we have a motion?

MS. SINGH: To adopt recommendation No. 1?

MS. DECKER: I so move.

MR. KERR: Second.

DR. ENTHOVEN: Moved and seconded.

All right. Discussion

Allan Zaremberg.

MR. ZAREMBERG: First of all, I don't think there's been a lot of information we have and there's a lot of information that I think people should consider before we make these choices. And first of all, I feel that I've had some background exposure on this, but I'm not sure everybody else has and maybe they have. I don't know if Barbara has a lot of information on it, but when you put rate bands and guaranteed issuance on all the

things in the 51 to 100 market, what are the consequences to it? And are the consequences the same as what we've seen in the small group market?

And I'd like to hear from people who market in that particular -- like Ron or somebody else, what are the consequences? And if the consequences are fewer PPOs when we're talking about expanding choice, the unintended consequence is we're actually limiting choice. And we found when we looked at the survey, that people were very much satisfied if they had the choice and the ability to be in a PPO, as well as a staffed HMO. And I think those are relative because I think compared to other insurance markets, I think you'll find the satisfaction level in health insurance is probably much more -- extremely higher than all other insurance; so you have to compare it. Relatively speaking, those were the higher limits.

So if you're eliminating the ability for people in this particular market segment, the employees and employers in that market segment to have access to PPOs, is that what you really want to do?

DR. ENTHOVEN: Well, Allan, we did discuss this and we thought that that was the reason the HIPC adopted risk adjustment, was to put the PPO on a level playing field and we had a little doubt about this. But apparently the latest returns were that the HIPC still has a surviving PPO.

MS. BOWNE: A surviving PPO.

DR. ENTHOVEN: Yeah, right.

MS. BOWNE: I think that needs to be very clear to the members of this committee --

DR. ENTHOVEN: Definitely clear. A surviving PPO.

MS. BOWNE: -- because this subject has been debated at the federal level; it's been debated extensively at the assembly level. There are many, many issues surrounding this, and so far, obviously it will come up again clearly because assembly and senate staff support it. But thus far at the federal level and the state level, it has been determined that small group so far and federal legislation is 2 to 50, and in the State of California it's 2 to 50.

And I think that we need to hear from the business people about this and from the insurers. Clearly there's no question that more choice is better, but in today's HIPC, we have one barely surviving PPO that needs a risk adjustor in order to be survived to be offered.

DR. ENTHOVEN: Clark Kerr.

MR. KERR: My impression is, though, that you don't have to belong to HIPC. I mean, it's a choice. And I would like to know if all the PPOs for 50 and 40, have they all been eliminated from the market or is it just that --

MS. BOWNE: No. They're in the market because they don't have guarantee issues --

MR. KERR: So, then, what you're saying doesn't make a lot of --

MS. BOWNE: -- excuse me, excuse me -- they don't have guarantee issue in the 50 to 100 and they don't have rate bands. They use insurance rating on the whole group. They still have the rule that they have to take the whole group. They cannot -- once they decide to take a group, you have to take everyone and their dependents in the group.

MR. KERR: In the HIPC?

MS. BOWNE: No. No. In the commercial market. In the PPO, the HMO, whatever market.

DR. ENTHOVEN: Go ahead.

MR. ZATKIN: We have supported this concept, but I would ask Michael whether there might be an issue about the breadth of the rate band that were mitigated against some of the points that were made.

MR. SHAPIRO: I don't want to belabor the extensive paper, we've already talked about that, but if you look at that paper, there's nothing in this recommendation that takes away the ability to mitigate what are known risks associated with purchasing pools. And I guess I am certainly open to ways of lessening flexibility or encouraging the direction of product designs from the market, lessening the likelihood of mid-sized businesses shifting to risk plans, and I don't think it's that black and white.

I think there are potentials for creating a purchasing pool for the mid-size market as based on the problems of discrimination, based on the lack of choice,

and based on the findings that we see in discrimination in that market where there is risk selection now by the insurance industry and allow those -- no one is forcing an employer to join a HIPC size 50 to 100. But there will be those choose to do that because of the advantages of the pooling arrangement, and the savings and costs to administer that and will think they are better off in a purchasing pool at 51 to 100 than being risk selected.

So this is not an employer mandate. This is a burden on insurance companies to abide by market rules which are identical with certain variations that were imposed in the small group market 2 to 50 with the same claims of increased rates and lack of choice.

Now, I understand the PPO issue. You don't have to join the purchasing pool. You still have access to PPOs, No. 1; No. 2, you can mitigate against that risk through risk adjustment and other (inaudible). So I understand the risks. The question is, since we walked away from federal risk amendments and we've indicated we have a choice problem, and this is the one that has the least risk in terms of adverse selection, we get down to individuals. It's really a problem, I will concede that point. This is the crown jewel because it's worked in 2 to 50. We have now companies that grow to 51, 52, 53 who are now back in risk selection market. They have lost their ability to use purchasing -- (inaudible.) And some may be able to cut at a deal and they are satisfied and get modest choices, but others don't; those employees

suffer because they lack choice. It could be mitigated.

DR. ENTHOVEN: Okay. Any other -- oh, sorry. Williams?

MR. WILLIAMS: Several issues. One, this is something that I think again represents a pretty extreme measure. I think when we look at the kind of market conduct which we saw in the 2 to 50 market and which was draft by 1672 which we were really one of the health plans that supported that. And the 1672 was really based in large part on some of the rating techniques that we had developed to increase access for small businesses.

I think I have not seen the evidence that there is any accessibility problem in the 51 to 100. What I have seen is that there is a bit of a fight among the distribution system, agents who tend to sell in the 2 to 25 range versus the brokers who tend to handle the larger employers. And part of this is about agents finding a simpler way and a simpler product to sell so they are in a better position to compete against brokers who are more sophisticated.

I think the other issues that are important is that this will result in less choice. There will be fewer PPOs as a result of this and consumers will not end up with the kind of choice that they have. I think also we'll end up with employers who are multistate who are rapidly growing and today have 15 employees and tomorrow 75 ending up going through some pretty significant changes. It's not at all unusual to see rapidly growing

companies in the Silicon Valley to start out with 50 or 75 employees and end up with 500 in a short period of time.

I think the final point I would make that is we'll end up with more people who shift to self insured outside of the system as a whole, and I think that I have not seen the evidence that there is a problem that warrants this kind of solution.

DR. ENTHOVEN: Steve?

MR. ZATKIN: Well, Alain, I already indicated that we have supported this. I think the issue of the PPO is not so much in the HIPC as outside, and I guess the question is, what the rate bands would be which would -- (inaudible.)

THE REPORTER: Excuse me, Mr. Zatkin, can you please raise your voice.

MR. ZATKIN: The question is, what would the rate bands be or would the intention be to establish rate bands that would mitigate against a loss of --

MR. SHAPIRO: I think if you look at the background paper there, somehow it indicated flexibility on the rate band issue to minimize risk associated with limits on it. And I'm not trying to put numbers in this proposal. I'm trying to recognize risks and say, here's a general proposition; the extent you're worried about product design being removed from the market or you're worried about a risk of flight, let's mitigate to the extent you can to minimize that but still preserve the option of choice in that market.

I don't know that that would indicate firmness to 50 to 100 level, but I do know that 95 percent of the growth in this state is in mid-size businesses and below who can't offer their employees a choice. And those are not your big PBGH companies and big companies. These are the ones that have been successful. They've grown out of 50 and they are now back in the risk selected market at the mercy of insurance companies who have been risk selected. Some of them are sophisticated and can handle it. Some don't. But there is a problem in this area and the intent was to deal with it.

DR. ENTHOVEN: Thank you.

Barbara Decker and then --

MR. ZAREMBERG: I just have a question.

DR. ENTHOVEN: -- Jennifer.

Okay.

MR. ZAREMBERG: We had Mr. Kritchlow here some time ago who offered testimony that he was setting up a private purchasing pool in the Bay Area for medium size businesses without the benefit of rate bands. Do we know whether that's -- I understand he's operating, do we know whether he requires rate bands to be --

DR. ENTHOVEN: Pretty early startup phase. They do a whole lot of risk adjusting by employer and by very sophisticated -- Sara, can you explain?

MS. SINGER They aren't actually applying the risk adjustment mechanism, but they have set up other mechanisms so that they can account for risks. And for

example, they have -- they require any plan that's participating in the group to offer an HMO and a PPO so that they have -- they're comparable -- they would each be exposed to comparable risk.

DR. ENTHOVEN: A month ago they had two or three accounts. They just kicked off.

MR. ZAREMBERG: And I'm kind of curious in terms of the goal in terms of, are we trying to ensure that employers from 51 to 100 have the opportunity to join a purchasing pool, and is it better to have a private sector purchasing pool like Mr. Kritchlow, or do we want as our goal here to put them in HIPC? And then if we put them in HIPC, do they have to have rate bands just like because Mr. Kritchlow isn't operating with guaranteed rate bands? And so I'm trying to find out what the goal is. Is the goal rate bands or is the goal the HIPC --

MR. SHAPIRO: I think the answer to the question in background paper is the findings of Mr. Mib and others is that you can't have an effective purchasing pool when you could be risk selected against by other companies not in that pool who were in the market. And the market rules are necessary to have a successful and effective purchase. And that's why the HIPC has told us and Mr. Mib told us, you can't simply have a purchasing pool and effectively deal with the risk selection problem unless you have the market rules accompanying that. That disciplines the market.

MR. WILLIAMS: How does every other health

plan compete against every other health plan?

DR. ENTHOVEN: They don't. They go for single plan replacement.

MS. BOWNE: Excuse me, Alain, but they are competing against other plans in that bid. And I think what I'm hearing you say, Mr. Shapiro, is that in order to enlarge Mr. Mib and the purchasing pool, we have to change the rules of the game for every one in 51 to 100 market so that we can make the HIPC bigger. Is that what you're saying? Because what you're doing, then, is taking a very small problem and turning it into a very large problem.

MS. O'SULLIVAN: It's not only the HIPC, right? This has to do with any kind of discrimination against these 50 to 100, right? It would stop the practice of discriminating against people because they are in a peculiar kind of business.

MS. BOWNE: Excuse me. I resent the term discrimination. If you're talking about experience rating a group based on past claims history and accepting all members within the group including their dependents --

MS. O'SULLIVAN: And changing their rates depending on whether they got sick the year before, yeah, that's what I'm talking about. I call it discrimination.

MS. BOWNE: Of the whole group. It's not to any individual member of the group. It's to the entire group.

DR. ENTHOVEN: We've got to get back on track here.

MS. SINGH: The question's been called without objection. We will vote on recommendation No. 1. Seeing no objection, those in favor of adopting recommendation -- alternate recommendation No. 1, please raise your right hand.

(Complies.)

MS. SINGH: 15 votes.

Those opposed?

(Complies.)

DR. ENTHOVEN: It needs 16 to pass.

MS. FINBERG: One more time.

(Complies.)

MS. SINGH: A division's been called, so please, those in favor of adopting alternate recommendation No. 1, please raise your right hand very high.

(Complies.)

MS. SINGH: I see 17. Recommendation has been adopted. 17 votes.

Those opposed?

(Complies.)

MS. SINGH: Four are in opposition.

DR. ENTHOVEN: All right. Now we will move to No. 2, which in the summary that we sent out was the task force recommends that the legislature enact a new law to increase consumer choice for all individuals -- individuals in this sense means people not in employment groups -- through individual insurance market reforms that

would allow individuals to purchase coverage through purchasing cooperatives and other insurance company products.

I have some comments of my own, but let the proponents of the idea have the floor first and then I'll ask Alice to put me on the list.

Michael?

MR. SHAPIRO: In view of the significant adverse selection of risks associated with this option relative to other options which were impressed upon me by the chairman and others, one of the things that was done in the papers sent out to the members was actually to modify this recommendation -- it's in the fax -- to actually indicate that in view of the significant adverse selection of risk associated with such reform must be submitted that would prevent serious adverse (inaudible) in the market as well as spread the cost widely across the market; mitigation provision should include, and there's a list in that to bear witness to that this really is a serious problem if you simply go ahead and open the individual market without substantial mitigation.

So I'd like the discussion not only to include the concept of a purchasing pool for individuals, but in light of the risk of people going in when they're sick and not using it otherwise to have significant recognition that you cannot do it unless you severely limit the process to litigate the risk. And rather than go through it, if I could just call your attention, I have

copies of the memo that lists numerous mitigations that must be -- must accompany that if you do it. I'm not advocating you do it absent those mitigations; so we're going to hear about the risks and the risks are serious. And I'm indicating that I'm only proposing this if, in fact, the mitigations are numerated by the group, I'm willing to consider further ones, or including but limited to; so we're not leading anyone to believe we're naive about the risks associated with -- (inaudible.)

MS. FINBERG: And what page are they?

MR. SHAPIRO: Page 5 of the --

MS. BOWNE: Excuse me. Can I have a copy?

DR. ENTHOVEN: Can you pass them out to everybody?

MR. SHAPIRO: (Complies.)

And while you're waiting, I'll read, the mitigation could include phase in reform, e.g., start with self-employed and then add other individuals; limited open enrollment periods, e.g., only month of birth; the use of preexisting condition exclusion periods; rate bands and risk adjustment; and there are others actually listed in the discussion that's towards us that can also be added to mitigate against the adverse selection associated with individuals getting in the market.

MS. BOWNE: We have --

MR. SHAPIRO: So that's on page 5, top of the page.

MS. SINGH: Mr. Lee?

MR. LEE: I was trying to be clear on what is before us, because there's the amendment we got in the mail and then Michael faxed the thing, the November 18 -- Michael's proposal we're considering is, as I understand it, the top of page 5 which is this mitigation explained recommendation.

Is that correct?

MS. SINGH: It's my understanding, Members, that right now what we are discussing is the alternate recommendation No. 2. That's what members were provided in there meeting packets.

MR. SHAPIRO: And for purposes of discussion, I'm suggesting it be modified to make sure we have these mitigation requirements which the chairman proposed to me and others at least part of the consideration of the motion, I'm modifying it for purposes of discussion.

MS. SINGH: Is there any other discussion?

DR. ENTHOVEN: Yes. I have a couple of thoughts, if I may.

MS. SINGH: Okay. Sorry.

DR. ENTHOVEN: This is about extending guaranteed issue to individuals. First, let me say I have long felt that this is a very attractive goal. I've done work on it myself to figure out how we could get there. I wish we knew how to do it. I do appreciate Michael accepting my suggestions that his revised wording would make it more palatable to people at the center, but I do

have a number of comments.

First of all, this is not specifically a managed care issue. It is a broad health insurance issue that exists with or without managed care. It's an important issue, but it's not specifically managed care improvement. It's a question of a large social program, not managed care improvement.

I regret -- this is picking up on what Rebecca Bowne was saying -- I regret very much that it was brought up so very late in this process, that we've been at it seven months, and this sort of came in right at the tail end of the last meeting and the members didn't have a chance to look at it.

I think that the danger or problem of adverse -- is adverse selection and a death spiral in premiums. I think we'd all look pretty foolish if we recommended something for which the evidence is pretty weak. Richard Figueroa has kindly deluged me with faxed material about studies that are soon going to come out. Here's a couple of ladies at Harvard who are finishing up a report, so there's a lot of stuff like that that's just about to come out.

And I got material implying that things were just terrific up in the State of Washington; so it happens that I have a few acquaintances up there because that's where I was born and grew up, and I have a communication from Gary Christianson about the basic health plan. And basically the news up there, and there's similar stories

in some other states --

MS. O'SULLIVAN: Who's this person that's writing?

DR. ENTHOVEN: The head of the Washington health care authority.

That the premiums for 1998 over 1997 are up by 72 percent. That is a death spiral.

Richard and Michael, I really would like you to hear this.

Characterized by various knowledgeable people as a death spiral is under way. Blue Cross last year lost 25 million dollars in the individual market. They're racing their premium 43 percent. Phil Nudleman, the president of Group Health Cooperative at Puget Sound who was a large proponent of guaranteed issue in the State of Washington saw it fail. And when this idea was presented to the president's quality commission, Nudleman led the opposition and characterized it as a failure.

The problem is that the costs of adverse selection have to be paid for somehow. Usually the idea is to kind of push them back onto the rest of the market. Well, the problem is, of course, you don't want to push them back onto the small group market and raise the number of people who are uninsured there. And because of ERISA and self insured plans, you can't push it back onto the large employer market because, then, they'll go self insured under ERISA. So we need to have something that does more good that harm.

I am not saying that it cannot be done. It may be through a package of things like measures such as the ones that Michael -- you can restrict it to a few people in which case it doesn't do much good. You know, long exclusion of preexisting conditions, annual enrollments on your birth date, rate bands and risk adjustment, liable for the whole year's premium if you sign up.

I mean, one of the things experienced up there is women signing up in the advanced stages of pregnancy. For example, maternity is seven times greater in this plan than it is in the general population for this guaranteed issue product. So there is statistical support for the anecdotes that one reads in the Wall Street Journal which I don't consider the most balanced authority on. But you know, this lady comes in in the eighth month and signs up and has her baby. And I'm not even saying there are not answers to that, but I think that the task force -- Michael, I think you ought to figure out how to do it and devise a plan for some limited experiments.

MR. SHAPIRO: Mr. Chairman, you have convinced me, and I want to say to you, I appreciate the comments you gave me prior and I have concluded that this work with drawing consideration from the group unlike the others, this one I recognize as a more significant risk. I wanted to discuss -- I appreciate the discussion you have raised and I recommend we withdraw consideration of this.

DR. ENTHOVEN: Okay. Thank you very much.

Okay. No. 3. Revise the Peace Bill to enable agents and brokers to establish purchasing alliances through the DOI, but incorporate additional provisions to track and prevent risk selection.

Who sent this, please?

DR. ROMERO: Clark.

MR. KERR: No. No. No, I didn't.

DR. ENTHOVEN: Is there a member who proposes No. 3?

MS. SINGH: It may have been Ms. Griffiths.

MR. SHAPIRO: I'll oppose it.

DR. ENTHOVEN: All right. No. 4. As a matter of DOI licensure, require agents and brokers -- I'm sorry -- to track and report to their appropriate regulatory authority and improve by 20 percent per year up to 75 percent of their book of business the proportion of their employer clients who offer a choice of health plans to employees.

MS. FINBERG: What are you reading from?

DR. ENTHOVEN: And, Clark?

MR. LEE: Some people are confused with this. As part of the attachment of the material we got was something entitled "Expanding Consumer Choice of Health Plan, Appendix."

MS. SINGH: Appendix.

MR. LEE: "Potential Amendments."

MS. SINGH: Behind the original paper that

was included in your meeting packet.

MR. LEE: Not on Michael's memo. This is not Michael's memo.

MR. SHAPIRO: It's not mine.

MS. SINGH: It's the paper right before tab V D. It's right before tab V D. It's after the paper. It's an appendix. It's in page document.

MR. LEE: It's in the originally mailed tabbed V C material at the very end of it.

MS. SINGH: But it's the last document right before V D.

MR. LEE: It's after page 16. It's starting renumbered page 1.

MS. FINBERG: Thank you.

MS. SINGH: Does everyone see that? The very last paper in V C. It's the last document. It's a stapled two-page document.

MR. LEE: We're on page 2 of that, recommendation four.

DR. ENTHOVEN: Does everyone have one now? It was in the packet 10 days in advance as a matter of DOI licensure.

Clark?

MR. KERR: This arose out of my impassioned plea at the end of the last meeting where I'm trying to get out of the box thinking and I realized that we didn't have a lot of it, so I was trying to think out of the box and I realized that we were boxed in which meant I tried

to think about who else wasn't in the ERISA complex and one was health plans and the other was brokers. So I figured somebody ought to take a stab at the brokers.

And I have to agree, this is a new untested unevaluated idea entirely, but the idea really was to look at people who to a certain extent are guiding where the system is going especially for the smaller employers. And these are the brokers who in doing -- the smaller employers have confidence in what they say. The idea basically was that if we were to require performance criteria on them as a point of licensure for them to be able to prove that they were actually getting results, doing something about convincing the employer to give them a choice, and then improving the number of their clients that actually had choice. That was a little bit of out of the box type thinking in terms of something that was feasible in California.

I honestly don't know if this will work or not. It has not been evaluated, but it's an option that isn't stopped by ERISA. It's partly borne out of frustration and trying to increase choice which I think is terribly critical if we are really going to talk about having a market and meeting some of the demands that the people in California told us to meet.

DR. ENTHOVEN: Peter Lee?

MR. LEE: A potential amendment to this is knowing that many are concerned about mandates but we also want much better information, is what if we were to state

this as require reports on an annual basis and DOI and do a summary report on the status to, then, in two years consider if there should be a mandate? This is as stated a mandate which may be appropriate, but since we don't have much information on how they're doing or not doing, it might be appropriate first to have two years and at which point the DOI consider mandating improvement; but for the first two years have them submit reports annually.

MR. KERR: One advantage to that is sentinel effect.

MR. LEE: Exactly. Would that be a friendly amendment?

MS. SINGH: Is there any objection to the technical amendment? I'm not sure all the members understand -- could you read it again, Mr. Lee?

MR. LEE: Instead of saying it's a matter of licensure, it says the Department of Insurance shall require agents and brokers to track and report on an annual basis the proportion of their employer clients who offer a choice of health plans to employees. The Department of Insurance shall produce an annual cumulative report of the status of a roll up report on an annual basis.

MS. SINGH: To who?

MR. LEE: Publicly a report -- I'm not sure. Do you think the idea of two years from now to consider?

MR. KERR: Two years seems reasonable, I think.

MS. SKUBIK: What would that do? How would that help the market?

MR. LEE: I think that would help the market by having the agents put on notice that we're all looking at this, and if they are doing a bad job, the Department of Insurance, the legislature is looking at mandating a requirement they have to approve.

DR. ENTHOVEN: It gives the issue visibility, creates and defines it as an issue.

MR. LEE: Right.

MR. WILLIAMS: I guess the question I have is, how does it affect their fiduciary obligation? They have a fiduciary -- they represent the employer and it's their job to get the employer the best deal that they can get. What happens if --

MR. KERR: That who can get? The employer or --

MR. WILLIAMS: The best deal that they can get on behalf of the --

MS. BOWNE: For the employer.

MR. WILLIAMS: For the employer. They are retained by the employer to represent the employer in negotiations with the health plans.

So my question is, they have a fiduciary obligation to that employer, and how does this affect their fiduciary obligations?

MR. LEE: I think as amended it doesn't. There may potentially be some conflict if offering more

choice is to the detriment of the employer in some way, but this reporting requirement couldn't impinge upon that fiduciary duty, I don't think. But it puts that question two years down the road.

MR. KERR: It would give that study to look into the issue and something to discuss.

DR. ENTHOVEN: Is this limited to the small group market or --

MS. BOWNE: No.

MR. LEE: This is for all employers.

MR. WILLIAMS: Would this cover consultants who are retained by the firm on a fee basis to advise the firm?

MR. SCHLAEGEL: Also brokers such as Mercer --

MR. WILLIAMS: Right.

DR. LEE: I think it should.

DR. KARPF: Who's going to monitor this?

MS. BOWNE: DOI.

MR. KERR: And you would assume they have the breakdown by sizes for the client, that of fiduciary.

DR. ENTHOVEN: Les, did you have your hand up?

MR. SCHLAEGEL: Yeah. I was going to put down that, you know, many of those consultants are brokers, but I think it should apply to consultants as well because you have consultation services to employers regarding health care coverage.

MR. LEE: So the agents, consultants, and brokers and that would be a known term of art?

MR. SHAPIRO: Can I get a comment? If the employer doesn't have jurisdiction, it doesn't work. It has to be licensee or someone -- you can't suddenly give them consultants.

DR. ENTHOVEN: Oh, doesn't have -- the jurisdiction over consultants does have over agents and brokers.

MR. SHAPIRO: Right.

DR. SPURLOCK: Not being an agent or broker, can I ask somebody what tools they might use other than their persuasive skills to cajole an employer to offer choice? I mean, what leverage do they have in the marketplace to be able to accomplish that? How would we set -- are we setting a goal for them or thinking about setting a goal that would be potentially impossible to meet? I don't know. I'm not --

MR. LEE: As of ended, it's not even setting a specific goal.

MR. HARTSHORN: It's simply out of their control. You're requiring -- I mean, your amendment doesn't -- it's like you're putting a burden on them that the employer may say, I don't want the choice. So where's the line that you cross?

MR. ZATKIN: I think Ron pointed out it's really maybe in conflict with the fiduciary obligation.

DR. KARPF: Call the motion.

DR. ENTHOVEN: Okay.

MS. SINGH: Is there any objection to the technical amendment, because this hasn't been moved to adopt yet?

Dr. Karpf, are you moving to amend recommendation four with the technical change?

DR. KARPF: Yes.

MR. LEE: Yes, that's what he's moving.

DR. KARPF: We're calling for a vote, so we can get it done.

MS. SINGH: We have to have a motion first.

MR. PEREZ: Second.

DR. ENTHOVEN: Discussion? All in favor of adopting the amended motion, please raise your right hand.

(Complies.)

MS. SINGH: Those opposed?

(Complies.)

MS. SINGH: Six in favor; eleven opposed. The motion fails.

DR. ENTHOVEN: Okay. No. 5. This is coming close to the end of our choice.

DR. KARPF: Mr. Chairman, can I point out that No. 5 is similar to what we've already discussed and we decided that we would at least table it for the time being, because it's the issue of a --

MS. RODRIGUEZ-TRIAS: No. This is the opting out in terms of quality.

MS. SKUBIK: Didn't you say you were going

to discuss it in December?

DR. KARPF: I would propose we discuss it as one overall package.

DR. ENTHOVEN: Michael, I think we need to -- with all due respect, I'd like to see if we can just do it fairly quickly here. I think we need --

DR. KARPF: Good luck.

DR. ENTHOVEN: Okay. So you have this required closed panel HMO product contract out of consumer dissatisfaction exit clause, aka POS, that gives a consumer access to indemnity coverage after a deductible is met such as a consumer plan to the medical group would have shared financial responsibility if a consumer opts out of the health plan's managed care panel due to quality or access concerns.

Do we have a motion from a member?

MS. SINGH: To adopt this recommendation?

MS. RODRIGUEZ-TRIAS: So moved.

DR. ENTHOVEN: Do we have a second?

MR. KERR: Second.

DR. ENTHOVEN: Discussion?

DR. ALPERT: There's a big part of this particular concept that I think there's a large misconception about, and that is the -- Rebecca actually talked about it before, a couple other people have, too, and we have a whole study on it that we were given this morning; and that is, the assumption that an opt out of any kind to go to presumably -- and I'll focus it this

way -- to a provider that is perceived as excellent, that you don't have access to in the coexis -- and the planning has. But that will cost significantly more. And we even asked -- the people even asked how much they were willing to pay and their comments made that there -- the mean wasn't enough.

I like this concept and I think you can word it in a way so it doesn't cost significantly more. I will just make a suggestion of what I'm trying to go to. In whatever circumstances you want this to be triggered, this opt out, it might only be in life threatening or life disabling conditions, that in those cases there's a universal opt out of some kind to go to providers who meet their plan's payment schedule, i.e., they agree to be paid in the same way that the plan would have paid their own provider, so there's no increased cost there, and meet the same quality standards.

And the only reason I bring that up is that that quirk and circumstance, that happens now. That happens on individual isolated cases, but it's not a situation where people are opting out, going somewhere else and being charged more. It's a situation where the providers are agreeing to accept the same discounted fee.

DR. ENTHOVEN: Okay. John Perez?

MR. PEREZ: I like the concept here, but I don't fully understand how you make it work, how you operationalize, you know, the dissatisfaction, and how you deal with some of the other issues that were just raised.

But I like the concept, so I'd be more interested in sending this back, get flushed out than on voting to kill it today.

(Laughing.)

MR. KERR: I second that.

DR. ENTHOVEN: Bruce Spurlock?

DR. SPURLOCK: I think the intent of this is incredible. I think people want to have that option. I think it's better placed in the dispute resolution period because I think that's where the opt out portion really goes. If you go through a mechanism that has dispute resolution with outside review under certain thresholds to certain circumstances, you actually include that process in that opt out.

At the same time, what you don't do and what I'm most concerned about what this process does, is it diminishes choices for the 30 percent of people who we saw on the slide this morning that are satisfied with the plan and don't want to look at anything else and don't need that opt out feature and they are perfectly comfortable with that, what you can call your basic health plan; that they don't need to have the POS type product in there. So by reducing that choice, you'd actually harm those people. And the opt out process can naturally go in a threshold way as Dr. Alpert said through dispute resolution process so that the same end will be there so that the patients can get a mechanism for help outside of the plan if it goes through a process that everybody agrees upon.

DR. ENTHOVEN: Thank you.

Hartshorn?

MR. HARTSHORN: Some of the studies that we've done which goes back a few years, but choice, when we asked consumers about choice, they want that; but when you drill down, they really want control, control to change doctors when they feel like, control to go to a specialist or something like this. So I think we need to maybe look at it from a different -- you know, rather than mandating it, we've got to do something, even if it's the dispute resolution because we have to deal with this issue.

We can stand smaller choice, I mean, the average person if the research is accurate, but when -- I'm stuck, I want to be able to move and so I still have choice, I have that control. Because this I can tell you will -- this would require every HMO basically to be a point of service plan. I don't think that's what we want. We want to have that control if there's some quality issues, if there are -- I don't know how to operationalize that.

DR. ENTHOVEN: Barbara Decker?

MS. DECKER: I have two items. Can somebody who maybe took notes or had privy to copies of the study this morning clarify when that question was asked about would you pay more, was that stated as to have another plan offering or to improve and have your HMO have an opt out?

MS. SKUBIK: I can read you the exact question. "Some employers in California today offer only one health plan -- health insurance plan to their employees. Some people have proposed that all employees be given a choice of plans with at least one plan allowing employees to pick any doctor they want. Under this proposal, employers would not be required to make any additional payments but workers would pay some additional money for insurance to allow them to pick any doctor they wanted."

Do you favor or oppose? For those who said favor, how much more would you be willing to pay each month out of your own pocket for a health insurance plan that allows you to pick any doctor you wanted?

MS. DECKER: Thank you.

I was trying to recall and refresh for the group that was really talking about a plan choice at open enrollment, not an opt out while you're in a treatment. So we're talking about two different things and operates in two different ways.

And then the other thing I'd like to share with you is in our population which is, you know, typical large employer, too much money, and all that other good stuff, but the people that are in the point of service plan are the least satisfied. They have the option of opting out and we get the worst ratings on our point of service plans compared to our HMOs.

DR. ENTHOVEN: That's because they're the

hardest to please.

MS. DECKER: You bet.

(Laughing.)

DR. ENTHOVEN: Thank you, Barbara.

Zatkin?

MR. ZATKIN: Well, I think it would -- a diminution of choice to establish this requirement as it stands. Now, if you're talking about a situation where you're going through a grievance procedure and there's been an official finding of a problem and how to reconcile that problem, that's different.

But this is basically a subjective decision by an enrollee, well, I'd really prefer and says there's an access or quality problem, who's going to judge that? As it's stated, it really becomes a subjective discussion to go out of plan when I decide to go out of plan. And it suggests here that that can be done on a cost neutral basis. I know that cannot be done on a cost neutral basis in our organization because we have fixed costs and establishing the out of plan benefit so that it exactly equals reduction in this plan use is a practical impossibility. It may be a theoretical possibility, but given our fixed costs and all the other things we have going on with unions and our physicians, we couldn't do that. So we'd have to -- it would raise our cost of our basic program and that's not fair to all the people who buy and are satisfied with the basic program. It really is a diminution.

DR. ENTHOVEN: Thank you.

Les Schlaegel?

MR. SCHLAEGEL: Everything has been said and I'll just agree that I think that dispute resolution, that's where this longs. There are people in our point of service plans, they get 90 to 95 percent of their care provided within the network, we charge them more, they're unhappy, and to think I'm going to go charge everybody else on the panel HMO to get that opt out that they don't need or don't want at this point in time, it's just -- (inaudible). But I like the idea of giving these folks who have a problem some opt out opportunity because once there's an agreement that there's a problem and not just because the patient says I don't like the care, I'm getting out.

MS. SINGH: The chairman would like to speak.

DR. ENTHOVEN: I put my name on the list here.

The reason I'm going to vote against this is because I think of my daughter, the part-time school teacher who loves her classic Kaiser treasures as her gold card and is really hurting financially, and just doesn't need to have another $1,000 a year added to her health insurance premiums. And I believe very strongly we have to preserve the opportunity for people who want to buy and need to buy really economical good quality care. So that's -- and I agree with Terry that this is really a

point of service by another name. These other alternatives sound very interesting, though, in dispute resolution. We ought to be thinking about that.

Northway?

DR. NORTHWAY: I agree with the same thing. Just one question. We do the right job in dispute resolution, this is where it belongs.

DR. ENTHOVEN: Clark?

MR. KERR: Just a concept. I hear all the arguments against it, and yet, I'm still intrigued. I don't like point of service because the way it is now, it's got -- you know, look at all the satisfaction rates down the tube, but it's maybe done wrong. Maybe it's the frustration, maybe it's not the concept that's wrong, maybe it's the way it's administered, but this might be an important safety valve for people. But the way the point of service works now is not the way I would certainly conceive it in our discussions.

I would conceive this as having at least -- it would really be an emergency safety value and it would have several requirements. The first one would be it wouldn't cover everything. It would cover only the most important critical lifesaving issues, like, if you're going to have in CABG a major gastrointestinal surgery or a major cancer case, so it's not something you opt out for every little thing, just major types of things.

Second, there is a danger that people opt out that there's some schmuck that was worse than the

people in the plans. So I think it's important that there would have to be a requirement that who you could opt out to in these emergency situations would have to be a gold -- a center of actioners I think Joan Trotter had stated -- a provider X to have proven to have better outcomes than normal.

And thirdly, I think there should be a requirement the person will have to agree they were going to opt out. It can only be in these emergency very life threatening type situations to a provider of known better than quality, high excellence care and that that group would have to agree to do the service at the same cost that the plan would pay for its own internal network so it could not cost the plan anymore. And what it would do -- so essentially what it would say is, you can't do it except when it's really an emergency, you can only go to groups that have been proven to be better than average. Thirdly, that that group to participate has to not only be better than average, they have to agree to be the same payment rates as the existing plan.

And I think in one sense -- we had a discussion of this on Wednesday, I belong to this RWJ provider -- patient provider initiatives project, and what it might do is it might spur competition in health plans; that you don't want people going out. So you would want to make sure that you've got gold standard people in your networks so there wouldn't be an inclination to do it because now you've got competition and it takes a lot.

There are copays, deductibles, the person will have to pay it and so on, it would be tough to go out. But if you don't get a good provider network, at least there's an option to have this happen. And for you not to have this happen, you make sure your own network is in that good quality.

MS. BOWNE: Can you call for a question?

DR. ENTHOVEN: Okay. To table?

MS. BOWNE: Second.

MEMBER: Second.

DR. ENTHOVEN: Without objection, would you take a vote, please.

MS. SINGH: Yeah. Basically --

MR. PEREZ: I'm moving to table until the time when we next come back to the rest of this document.

DR. ENTHOVEN: And/or the related document --

MR. PEREZ: Right.

DR. ENTHOVEN: -- of the dispute resolution?

MS. O'SULLIVAN: Second.

DR. ENTHOVEN: All in favor?

(Complies.)

MS. SINGH: 19 in favor.

Those opposed?

(Complies.)

DR. ENTHOVEN: We have just completed action for today on the expanding consumer choice paper. I'd like to proceed next to the paper on provider incentives

which is the next on our list.

MR. PEREZ: Don't we have item E or did we already --

DR. ENTHOVEN: We dealt with that.

MS. DECKER: We did "E."

DR. ENTHOVEN: It barely scrapped through, but it did.

So we have done A, B, C, D, E and now we're going to go to Roman numeral VI, item A. Discussion of the provider incentives paper.

MR. LEE: Tab VI A.

DR. ENTHOVEN: We have several members of the general public who wish to speak. I'll recognize them now in the order in which they appeared. Again, I'd like to remind you that we really have to enforce the three-minute limit, so please make it to the point.

Is Maureen O'Haren here from California Association of Health Plans, the provider incentives paper?

MR. SHAPIRO: Mr. Chairman, I have a question. On the discussion papers, are we taking public comment before our discussions?

DR. ENTHOVEN: Oh.

MR. SHAPIRO: I'd rather save time for us and give Maureen a shot later. I'm all for public participation, but we only have an hour left.

DR. ENTHOVEN: You're right. Michael, I apologize. I claim to be a distinguished health care

economist, but when it comes to all this procedural stuff, I know I'm a klutz.

MR. PEREZ: Mr. Chairman, given that it's now 6:00 and we talked about getting out of here by 7:00 and there's four items before us, can we impose some sort of time limits on some of these discussions?

DR. ENTHOVEN: Well, I thought we would do one hour on the provider incentives paper.

MR. SHAPIRO: And then none on the others?

DR. ENTHOVEN: And none of the others.

DR. KARPF: They are on schedule for tomorrow anyway.

MR. LEE: Well, really the discussions for other papers will have to be less than budgeted to even spread them over the next two days. That's one of the cost of having nonsignificant in the -- (inaudible.)

MS. BOWNE: We're going to volunteer for the medical center to save time.

DR. KARPF: We will have a few more corrections but we will take less time.

DR. ENTHOVEN: Provider incentives, Donna -- is Donna here?

MS. SINGH: She was ill.

DR. ENTHOVEN: Steve, we are beginning the discussion of the provider incentives paper because this is a discussion, not a vote.

MR. LEE: So are we asking for the ERG people to present it first and then --

DR. ENTHOVEN: Yes, that's right. Then we will -- let's have like 15 minutes of general discussion. We're talking here about 2.2 pages. We have allocated an hour and a quarter, but we may be able to do it faster. Let's start with some general discussion by the presenters and any major opposers, and then we will start walking through the recommendations where we won't be taking a formal vote, but we will be trying to fine tune them to enhance their general acceptability.

MR. ZATKIN: We did discuss this issue previously with the task force and I believe that our findings reflect that discussion. I'm going to highlight a couple of them.

One, that all compensation arrangements contain incentives which may have positive and negative effects; secondly, that there are almost an infinite array of compensation arrangements. They are very complex, and in most instances, not amenable to regulation. HCFA did struggle mightily. I think it took several years before they actually enacted the rule subsequent to the adoption of the statute. And I think we need to be mindful of that as we go through this area.

Also, there is no conclusive evidence of the relationship between specific financial arrangements and adverse outcomes, and that's an important item. However, as we note in our proposed findings, there are some arrangements that we believe that are not in the public interest and should be restricted because they create too

great an incentive to deny necessary care. In general, the greater the intensity of incentives, the more likely they are to affect specific clinical decisions which is what one wishes to avoid at least when one is talking about financial incentives.

A particular concern are incentives which place an individual or small group of health group practitioners at risk for the cost of referrals for their patients. Stop loss insurance, reinsurance, and risk adjusted patients -- or payments can alleviate some of the potential problems.

Now, that's really the heart of our findings. And also, we noted that there is some law on this subject. Already the state requires health plan disclosure of -- that that has incentives. Federal law for MediCare and Medicaid beneficiaries requires disclosure of incentive arrangements where physicians are placed at substantial financial risk. That is a term of art and it means that the physician has at least 25 percent of his or her income at risk for the cost of referrals, unless the physician is part of a large patient group with a large patient panel.

In terms of our recommendations, we recommend that health plans be required to disclose to the public the general methods of payment made to contracting medical groups or help practitioners in the types of financial incentive used and it is the last clause which is new. Current law covers the first. And we recommend

that this be done through clear and simple language, and that if an individual wishes to know more about their providers or groups' method of reimbursement, they should inquire.

We recommend a pilot project with medical groups in order to develop a method for disclosure by them. And whatever agency is appropriate here ought to do it. We recommend that provider groups and health practitioners be required to disclose method of compensation and financial incentives they receive upon the request of a patient and that groups be required to disclose methods of compensation and incentives paid to their subcontracting providers. And in this instance, we had to balance some interests.

If you'll remember our discussion previously, there was a recommendation by at least one task force member that we go so far as requiring disclosure of the amount of the compensation and we didn't feel that that was appropriate. First of all, because it probably wasn't meaningful to most individuals and we were mindful of the attempt to balance patient trust and the patient, provider relationship with the desirability of disclosure.

Now, our fourth recommendation is the most regulatory in nature, and in that sense, requires close attention. What we're recommending here is the prohibition of a particular incentive arrangement which we believe would create substantial intensity as it applies

to an individual physician. And this would be a capitation arrangement that includes the cost of professional services for that practitioner's patients.

Now, we don't know how much that occurs in this state. We've been unable to determine that. And we're also mindful of the points earlier made about the fact that there is no direct evidence that this arrangement actually causes -- has actually caused harm. But we do feel that there is a potential ethical conflict that is raised in this situation, and I, in particular, was persuaded by descriptions that were included in a document prepared by an organization called the governance committee of the advisory board company which is really an industry consulting firm, and its -- one would not accuse it of having a strong bias in favor of regulation.

And what they said was -- and they were talking about individual capitation involving risk for all professional services -- they said, "The unbridled force of individual capitation poses clear and present danger of under utilization absent reliable outcomes data, no way of knowing extent of problem."

Now, they did say also that there could be mitigation through risk floors and ceilings and potentially through quality reviews. They also categorized this arrangement later on as being excessively advantaged, meaning that it was -- the potential for strong cost control perhaps too strong was there.

Now, I will say also that I had a discussion

with Steven Lathem who's an attorney with the American Medical Association in charge of their ethics program and who wrote a very fine paper that was included in your material that you hopefully read. And I actually talked to him on the way up here. I've been trying to reach him, and I did ask him whether in his opinion if we applied the stop loss requirements under federal law to this kind of arrangement whether it would mitigate potentially some of the problems, and he thought it would.

So I just leave that for you because we also do recommend the stop loss for all physicians in this circumstance. That's recommendation IV A, and that is a recommendation for a prohibition.

MEMBER : Can I -- (inaudible.)

MR. ZATKIN: Okay. IV B is a second class incentive arrangement that we addressed. And here we do not recommend a prohibition. We recommend careful review by the regulatory agency and a determination by them that there is appropriate protection including stop loss and the other mechanisms enumerated. And in the absence of a finding of that appropriate protection, then this kind of arrangement also would not be permitted, but it is not a recommendation to prohibit.

DR. ENTHOVEN: Steve, is very small -- what numbers go with that in your mind?

MR. ZATKIN: Under five.

MR. HARTSHORN: Steve?

MR. ZATKIN: Yes.

MR. HARTSHORN: I think I'm lost in the wording. Maybe it's the time of day. What's the difference between A and B where you're recommending a band and the other one is where --

MR. ZATKIN: You mean what class of arrangements are we talking about in B versus A?

MR. HARTSHORN: Yes.

MR. ZATKIN: "A" involves capitation which includes the cost of professional services for referral. "B," one class of arrangement in B would be a capitation to a small group of the type that I just referred; so it's not capitation to an individual, it's capitation to a small group.

MR. HARTSHORN: To a small group.

MR. ZATKIN: Under five.

And then the second --

MS. BOWNE: Steve, under five physicians, a small group practice, not a small group of employees?

MR. ZATKIN: Yes.

A second class of arrangements is an individual practitioner who receives an incentive tied to the cost of referral for that practitioner's patients, but it's not a capitationism. It may be a bonus or -- (inaudible.)

DR. GILBERT: So A you capped for the primary and specialty individual, and B, that same issue with a small group. But then the other one even a risk pool that's paid in retro, would be a problem if it's a

specialty risk --

MR. ZATKIN: It's not a problem, if you will. How would we term it, Sara?

MS. SINGER Suspicious class.

MR. ZATKIN: A group that should get close scrutiny by the reviewing agency in reviewing --

DR. ENTHOVEN: Suspect class is what it was for a while.

DR. GILBERT: Do you differentiate between incentives that are tied to individual decisions versus total decisions over time or not?

MR. ZATKIN: The line relates to -- first of all, it's an individual; secondly, the individual is at risk for the cost of referral for that practitioner's patients.

And then the third thing we recommended under four is the extension of the federal rule requiring the provision of stop loss coverage for health practitioners at substantial financial risk. Remember, that's defined being at risk for 25 percent of your income for cost of referrals. Extending that rule to state law, because while most plans have a MediCare or -- MediCare or Medicaid contract, not all do and not all provider groups do as well. And so four is a little complicated. But we're basically recommending consideration of prohibiting one type of arrangement, so-called nuclear capitation, and then putting a close review on these other types of arrangements that involve either individual physicians or

small -- or very small groups, and then we're proposing to extend the federal rule around stop loss.

Recommendation five is --

MR. RODGERS: Can I ask you one question?

DR. ZATKIN: Sure.

MR. RODGERS: Are you assuming that DOC reviews right now, reviews small groups because you say DOC should not approve? They don't review all the small groups at this point.

MR. ZATKIN: Well, Sara, why don't you tell us what you've done with that.

MS. SINGER When I spoke to the Department of Corporations, they said they do as a matter of looking at the health plans look also at the health plan's contracts with the medical groups and that the medical groups --

MR. RODGERS: Sara, do they look at all 190?

MS. SINGER No. They do cursory reviews, but they look at them.

MR. ZATKIN: So in a sense, what this says is, here's some areas to focus on. Now --

MR. RODGERS: I'm just saying, don't expect -- DOC does not look at the groups underneath the IPAs.

MR. ZATKIN: This would say that they should.

MR. RODGERS: You make that assumption, fine.

MR. ZATKIN: But this is a very challenging area because there are lots of arrangements and DOC or whoever is going to have a limited capacity in terms of both intellectual and manpower to do this. And that's why we put in No. 6 which was to establish sort of a private sector approach to looking at this and not something that the government should mandate but to have the health plan associations and the medical -- various medical associations try to identify both the best practices and even perhaps some of the questionable practices.

Now, I was cautioned by Steve Lathem in the car and I should have known this as a lawyer, that there might be an antitrust issue in doing this because of restrictions around getting into pricing. And that's something I think the association would want to look at.

But one of the things that struck me in going through all this material is how little attention has been paid to this issue except by the consultants who advise how to do this in order to move the process but not from a public policy standpoint as to what are the implications.

And there is some literature on that, but not a lot of attention; so I think, in general, that our recommendations are pretty moderate in that they're not prohibiting anything except one thing. I would welcome a discussion about that one arrangement because I know there are different points of view about whether that is an arrangement that deserves to be prohibited. But that in a

nutshell is what we did.

DR. ENTHOVEN: Thank you, Steve.

A lot of work went into that. Including we had from our school Margaret Holland who is a very talented student who worked for six years in HCFA and knew an awful lot about this and who wrote the basic staff paper with help from Steve Lathem.

Are there questions?

DR. SPURLOCK: I have some comments and talk about some of the fuzzy areas that I think Steve alluded to. I want to tackle No. 4 and work my way backwards from C through A.

I think -- I just want to make a statement about C that I think that's a great idea to include that to the commercial market. My experience and expectations that the vast majority of practitioners are already in the MediCare market and already meeting their requirements. That won't be a great challenge for them to do. There may be a few people that that picks up, so it will pick up some of the folks who don't have MediCare. But in California, MediCare is the big money winner for the vast majority of practitioners, and I think that will be a good change.

I do think that it will be a challenge for DOC from a manpower standpoint to simply -- even at less than five or 3,000 -- at least 3,000 medical groups in California that will need to have their arrangements examined; so I think that what will end up happening are

different buckets of examination and different buckets of patterns that DOC will have to look at to see if people fall anywhere near those buckets. And we're talking about the reference packages.

The area that I kind of want to spend the most time, though, is on IV A and that's because it deals with a prohibition as you can imagine. In my concept of dealing with prohibition is that we should definitely -- where there's a bright line, anything above or out of scope of that bright line we should not definitely prohibit that. And so for me, if you look at the cap dollar, if you look at the way that incentives happen or anything that goes on with practitioners with all the providers that go on, you know, hospital services, pharmacy services, out of area network services, all of those things in my view are clearly above that line. It's very, very bright. So if you have professional services and hospital services, for example, I could see that as an absolute prohibition. I don't think it happens. I don't think it happened in California. But we wouldn't want it to happen in any of the circumstances in the future if somebody wanted to push that envelope.

I think in the area of referrals, though, and specifically in professional services, I think it's a little greater. And partly because if I think about how I manage my own patients, the necessity of making appropriate decisions is what we're really trying to get at. And one of the things that capitation in a sense has

done has changed some incentive to do inappropriate behavior.

When I was in medical school a patient came in with chest pain, we used to get a VQ scan, a treadmill, and a CT scan all in the same day simply because we didn't know what was going to come up first and there was no disincentive to do all those to find out the person had a pulmonary embolism -- had a myocardial infarction; so we just did everything, sort of a shotgun approach to doing medicine. And so with some of the cost controls, we don't behave that way. We have to think a lot more strategically how to solve those problems clinically.

It could be that actually it's more appropriate to do a referral than to do a test because, A, you get a better answer; and B, it's more cost effective. Or it could be that it's more cost effective to do a test. For example, a CT scan rather than a neurology appointment so that you may not actually do the referral, and therefore, you have the appropriate behavior.

I guess what I'm saying is that it's fuzzy to me. It's extremely fuzzy when you talk about physician's services and unethical behavior at an individual level. What's the most appropriate line to draw in there? Because we definitely want to have that appropriate behavior gauge on there, the regulator, the thermostat on there so that people know and can think about these things logically and do what I did when I first was in medical school and go to the shotgun

approach. And then we don't want to have people reducing behaviors unnecessarily; so I would say the line is absolutely clear above the physician's services, physician and hospital services.

And what I think we probably need to do is to explore the nuances below that on the an individual practitioner. I think that's the area that probably needs to have more much debate before we have an absent prohibition against the cost of referrals.

DR. ENTHOVEN: J.D. Northway?

DR. NORTHWAY: I'll pass.

DR. ENTHOVEN: Terry Hartshorn?

MR. HARTSHORN: I support the recommendations one through three, and I was going to focus on four as well, IV A. And I guess I would -- I don't know how many of these arrangements exist around the state, but there's thousands.

MR. ZATKIN: Actually, I tried to solicit -- we tried to solicit input from the groups who should know, like, the IPA associations and the medical group associations and we didn't really hear.

And Maureen, you don't know, do you?

MEMBER: Can you speak up, Steve?

MR. HARTSHORN: I come close to what Bruce was saying. Maybe we need to study it or empower somebody to look to take a look to see if there's really a challenge here. Because you could take any payment arrangement and shoot holes in it, and why do we pick this

one out?

MR. ZATKIN: I picked it out because of -- besides the literature I read, what I quoted to you from the advisory boards which you're probably familiar with, Terry, they are not exactly -- that's not consumer union talk, that's the way --

(Laughter.)

MR. ZATKIN: -- this is way in the industry where the real --

MR. HARTSHORN: Well, I guess my point is, we might end up reducing access to care if this is banned and there are physicians that want it or health plans that like it or whatever, you know, and you may have a geographic area or areas and there is a purpose. It may not. Maybe we just need a little more data. That's all I'm saying. What's the impact of this band? Not everybody will be willing to convert.

MR. ZATKIN: I don't know. When I ask folks about it, and that's not a scientific basis, they say, do you have individual physicians in capitation? Yes. For their own services or for professional services? Their own services, typically. Nobody has told me -- I haven't found anybody who does this, but maybe --

DR. GILBERT: Absolutely. What happens is what Tony is talking about, it's a subgroup below the IPA. What they do is they -- the health plan capitates the IPA for all professional services and whatever, and then they take their chunk off and then they subcap a very small

group for usually professional services, more than pharmacy and some of the other issues.

MR. ZATKIN: We're talking about IV A. IV A is one individual --

DR. GILBERT: They can do it both ways. I've seen it both ways. Is it my turn?

The concern I have is the potential it creates. And although I agree, I don't think there's evidence that truly we can demonstrate that adverse outcomes have occurred. In today's world where compensations are decreasing, there's a great temptation for people to draw down as much as they can and the potential this creates -- Bruce, for people that don't act in good faith, is the income is correctly attached to that decision they make. It's sort of the same as in the physician labs. And I see it as sort of as a physician office lab where in the old days your income was directly related to every test you ordered, and there's been some issues related to that and some legislation about that.

And to me it's the potential. And when an individual doctor, it's his individual decisions on patients that he would be directly incentivized not to do because he already received the money; so I would support the band.

DR. ENTHOVEN: Helen Rodriguez-Trias?

MS. RODRIGUEZ-TRIAS: Did I ask?

(Laughter.)

MR. SHAPIRO: These documents were faxed out

November 7th. I'm only going to touch on four points. I want to start at the back. I'm only going to mention four items that were referenced in the background material paper which were not reflected in the recommendation.

The last item of what I'm handing out will say No. 5. The background incurred capitation arrangements --

DR. ENTHOVEN: May I have a copy?

MR. SHAPIRO: I'm on the last page.

I want to encourage -- this not a mandate, I want to encourage compensation arrangements that include rewards for quality care consumer satisfaction and other nonfinancial factors. This is something that Milstein and PBGH says they're encouraging their folks to do. So we have an encouragement issue here, No. 5, where large purchasers are asking for best practices. The background suggests this is something that should be merged with financial incentives. One of my suggestions is that we encourage including nonfinancial quality consumer factors along with financial. The last bold in No. 5.

DR. NORTHWAY: What's this got to do with No. 4?

MR. SHAPIRO: I'm doing one thing at a time. I was recognizing that these are general --

DR. NORTHWAY: Okay.

DR. ENTHOVEN: One thing that would just help on this, continue to review since some of them are doing it?

MR. SHAPIRO: That's fine. I just want some encouragement of the noneconomic factors.

DR. ENTHOVEN: Could this relate to item six in the paper, that is, industry group with CMA, age, and so forth?

MR. LEE: This is a specific recommendation to amend No. 5. without any added language.

MR. SHAPIRO. Right.

MR. LEE: So taking that type with a couple additions, I would guess, not speaking for the ERG authors, but this would probably be a friendly amendment.

MR. SHAPIRO: This was supported in the papers and supported in the background.

I'd like to move on one step to IV B.

MR. LEE: Before you move on, it might be helpful to take a straw poll to see what people think because next time we're going to come back and vote on it. It would be helpful now before we move on to see if people think it's a good idea or a bad idea.

MR. ZATKIN: Michael, I'll react to five. I think five is reasonable. It doesn't concern me.

MR. LEE: We don't even need a straw poll to incorporate that before it comes back?

DR. ENTHOVEN: So five -- so the Shapiro amendments to five are okay?

MEMBER: Yes.

MR. LEE: Right.

MR. SHAPIRO: I'm not going to talk a lot

about this. I'll leave that up to you on the editorial. Take it or leave it. I'm just going to cover four.

The next one I want to talk to you is on that same page, one step above IV B. The top paragraph in four is the current recommendation, and that's to basically adopt half of a federal rule that's been imposed that deals with financial risk faced by treating physicians. That's the stop loss coverage division. That same rule which is referenced in the background paper requires those same plans that are now filing it to do surveys, and provide among other things, disenrollment data. That portion of the regulation which is referenced in the background package is not part of the recommendation. I'll make clarification on that.

My suggestion is the federal rule that applies to HMOs in California that requires stop loss and surveys with disenrollment information --

MS. DECKER: For MediCare patients?

MR. SHAPIRO: Now to be applied to all commercial plans so we get that same disenrollment information.

DR. ENTHOVEN: Ron?

MR. WILLIAMS: I think the objective, again, is good objective. The question is, which surveys do I do? Do I do the PBGH survey? Do I do this survey? Do I do the survey that another major employer wants done?

MR. SHAPIRO: You can do the same survey you do for the federal government with the other two clients.

MR. WILLIAMS: But suppose you're not in the MediCare risk group?

MR. SHAPIRO: I'm not dictating the survey.

DR. ENTHOVEN: CalPERS has been doing this for some time. I know because I spent a lot of time on it and they do a disenrollment survey which we've used as a diagnostic instrument for under service, risk selection, other bad behaviors, and so forth. And so, I just wonder if there's a need for another -- also, if you want them to do their own survey, I think that is being a lot better if CALPERs, PBGH or some independent entity has more credibility rather than the health plan itself.

MR. WILLIAMS: It's not against a survey. I think a good third party independent survey has lots of value. It seems that some of this is at such a micro level of management and not integrated with other activities that are ongoing and are parts of industry absorption --

MR. SHAPIRO: I think the point I was making, I'm not whetted to how we do it. The government said in light of some of the risks associated with physicians, we want to see if it's having an impact on patients. And if patients are leaving those physician groups where we have these intense financial incentives, so we are requiring not only stop loss insurance, but we're requiring surveys that have disenrollment data so we can see if patients are suffering because of this.

That portion of the rule is not part of the

recommendation. I'm not whetted to who does the survey or whether it's another group, but there are plans in this state that are not covered by the federal rule where we will not have that disenrollment data unless PBGH happens to be doing it or CalPERS. And that disenrollment data was critical enough for the federal government to adopt the rule and say, where we have this intense physician risk, we want to make sure from this disenrollment data that we can track this. And not whetted as to how you do it.

MS. BOWNE: But the philosophy behind the rule in HCFA and the Congress was because you were dealing with an elderly population and the fact that the government is designing new policies to encourage and incent MediCare enrollees into these plans and was specifically designed for that population which I think we need to think pretty long and hard about before that's transferred to the entire commercial population.

MS. O'SULLIVAN: It's not only physicians at substantial financial risk.

MEMBER: Well, it is to the entire commercial --

MS. BOWNE: To the entire commercial population.

MS. O'SULLIVAN: But not enrollees of all physicians. Only this particular class of physicians.

MS. BOWNE: That's still a huge, huge --

MR. HARTSHORN: I think we -- I guess I'm

with Rebecca because it's a very burdensome survey that HFCA requires. I agree with the Ron and I agree with the concept where we need to do something, but here we've got NCQA, we've got a multi industry group, how many things are we going to layer on the industry? Let's pick one and kind of agree on it and get the data we need, and I think everybody will line up behind you.

DR. ENTHOVEN: The main thrust of our regulatory organization story is going to be, let's get all these entities to get together and create one inspection, one survey, so forth, and do it periodically and then once and for all rather than multiple things. Maybe we can tie that to this.

Let's see. I have Spurlock, and then Karpf.

DR. SPURLOCK: Thank you, Mr. Chairman.

I just want to make two points. And I think we're having a little clarity problem on the HCFA rule, because if it applies to physician groups, if you have more than 25,000 patients in your enrollee group, you are exempt from stop loss. Second of all, the disenrollment is at the hospital plan level and not at the treating physician level or the medical group level; so I think we're kind of mixing metaphors here with that.

I do think that there is value in getting disenrollment data. I think what, Michael, you're getting at is, you want to drill down to get at the medical group level.

MR. SHAPIRO: Only in these very high risk

situations.

DR. SPURLOCK Okay. But we've got to be really clear when we do that on several things. First of all, is it the group that has 25,000 or more or not? Because actually, that's where you probably have richer data and they're not even required in the first place to stop loss; so that's one of the things. And second of all, if we do that, and I'm all for CCHR or whoever is going to do this process doing disenrollment data, is to really to understand the factors of disenrollment and understand what the medical groups actually have control on. Because if you have people that disenroll because their employers switched groups, it really skews the whole population so we show data that has no meaning to it.

And I think it's got to be much more clearer about what we're saying when we're saying disenrollment and who it's affecting, and who are the levers on that process. I think to be honest with you, it's a business imperative if you do that. I think both the plans and the medical groups want that information because it makes them better providers and it keeps their members with them better. So I think we have a huge incentive to do that and we need to do it in a way that makes sense. And when the public gets that information, it's meaningful information.

MR. SHAPIRO: One last point on the paper. I don't want to move or push others out.

In the background paper there was a GAO

report that was referenced. It's now on the second page dealing with Steve's conditions before DOC could deal with a small group. It's the item dealing with the timing of payments. It's the third bullet from the bottom. And I'm not going to advocate the CMA predictions. I just threw those in because CMA suggested other -- (inaudible), but I only mentioned -- the paper had support for protecting small groups from payment schedules that were too intense and had a finding reference in the background, that that could lead to adverse outcomes. I only reference it because it was in the background, but I didn't see it here. If it's not worthy of support for some good reason, I'm not going to push it.

DR. ENTHOVEN: Brad Gilbert raised that earlier and then it kind of got brushed aside. This is to do with the periodicity. You don't want the payments to be -- Lathem made that argument -- month by month. You'd like to spread it over a year or something so that there's more averaging which you want.

MR. ZATKIN: That's appropriate.

DR. ENTHOVEN: Do we need to think about to bring this into -- item four, bring periodicity into that?

MS. DECKER: Can you just explain that a little bit more so I understand it? A few more words.

MR. ZATKIN: In terms of the time period?

MS. DECKER: Just mechanically what are you saying? What's periodicity?

MR. ZATKIN: When the physician receives

payments and over what period of time, whether it's concentrated or extended over a long period of time will affect the extent to which the physician may be incentivized with respect to a particular clinical event.

MS. DECKER: So you're saying instead of thinking monthly capitation, do capitation on a different basis?

MR. ZATKIN: It could be -- the payment may be at the end of the year, it may be monthly, and depending on when it occurs, it may have an effect on the --

MR. SHAPIRO: At one point the incentive to withhold another thing which might influence you. So it needs to be worked on as a concept. It seems to me it was supported in the document. I'm not whetted to my language. I just drew it from the document. The concept was to think about that issue as one of the ways of protecting against.

DR. ENTHOVEN: Perez?

MR. PEREZ: Move to terminate discussion at 7:00 sharp.

(Laughter.)

DR. ENTHOVEN: There's no vote. This is just discussion. We are, I think, doing very well here. I think there was great discussion here and I thank you for -- I thought you were going to say right now.

MR. PEREZ: No. I want to give us a little advance notice, but --

MS. BOWNE: Excuse me. We should allow time for our public testimony.

DR. ENTHOVEN: Yeah. I'll stay for that and any other --

MS. BOWNE: No. Within the 7:00.

MS. FARBER: Could we do a straw poll now just to see how people feel about this?

MR. ZATKIN: I wanted to respond to the question about the survey because we did consider that and we didn't include it. Not because there might not be some value to it, we were trying to focus on what we thought were the essentials which was the stop loss, et cetera, and trying to not have a great burden on the plans because we thought most of the plans that would be effected by this would be the smaller plans.

MR. SHAPIRO: I just said there were things in the background that were there and I didn't know why.

DR. ENTHOVEN: Let me kind of march people quickly through, if I may, the recommendations one at a time. And as Nancy was suggesting, a straw vote and any quickly stated key points that might have to be -- that ought to be modified.

Okay. The recommendation one; although, I just -- Steve, I have a question which I have to ask, which is, isn't No. 1 already in Knox-Keene?

MR. ZATKIN: No. Part of it is and part of it isn't. The types of financial incentives used is not current law. There is a bill that I think Rosenthal --

DR. ENTHOVEN: I accept that.

Could I ask for a straw vote for each one, then?

MS. O'SULLIVAN: You said you would take comments at the same time. Do you want to do that or no?

DR. ENTHOVEN: I guess if they could be very --

MS. O'SULLIVAN: Real quick. Just to say don't we want to include disclosure to DOC as part of that?

DR. ENTHOVEN: We're going to get to that in which paper? That's a big thing. Regulatory to --

DR. ROMERO: Not regulatory.

DR. ENTHOVEN: Doctor/patient. We do have a big thing about disclosure where the idea is going to be to have disclosure at the medical group IPA or other at risk provider levels.

MR. PEREZ: That's a doctor/patient.

MS. O'SULLIVAN: I'm suggesting that what we're asking for here is that information be disclosed publicly and to patients who want it. I'm saying that that same information ought to get handed over to DOC.

DR. ENTHOVEN: Do you think DOC can find it?

(Laughter.)

MS. BOWNE: Alain, in the rare event that we might be persuaded by public testimony that would be knowledgeable, don't you think before you take the votes it might be wise to hear that?

MR. LEE: Then their comments can be informed by where the task force is leading.

DR. ENTHOVEN: Yeah.

MS. BOWNE: I just don't see any sense in taking votes.

DR. ENTHOVEN: I just want to give some guidance to the authors here.

MS. BOWNE: Well, we've given guidance. If people hadn't uproarously objected, then they probably are okay.

(Laughter.)

DR. ENTHOVEN: Very quickly. Straw vote. All who agree with No. 1 -- will send there fine tunings --

(Complies.)

DR. ENTHOVEN: Okay.

All who agree with No. 2?

(Complies.)

DR. ENTHOVEN: All who agree with No. 3?

MS. O'SULLIVAN: Wait. I have a small suggestion, comment for No. 3. Could we include in there that we're talking about not just -- we say referrals, but we just don't say what that means, it's hard to know. I assume it means referrals to specialists. Can it also mean referrals to hospitals and lab services?

MS. BOWNE: It says subcontracting providers.

MS. O'SULLIVAN: On No. 4 --

DR. ENTHOVEN: We are on three.

MS. O'SULLIVAN: Oh, I'm sorry.

DR. ENTHOVEN: It's quite all right. I get confused also.

Everyone's okay with three?

(Complies.)

MR. HARTSHORN: As long as we're not -- it's just the method.

MS. SEVERONI: Just the method.

DR. ENTHOVEN: That's understood to be method and not money. We straw voted that before.

No. 4 --

MEMBER: Let's do A, B, and C scale.

DR. ENTHOVEN: IV A --

MS. O'SULLIVAN: Can I say something about that?

DR. ENTHOVEN: Yeah.

MS. O'SULLIVAN: For A and B, would you all consider including -- being clear that what referrals refers to.

DR. ENTHOVEN: Yes.

MS. O'SULLIVAN: And I'm suggesting that it refer to specialists and pharmaceuticals and lab services and hospitalization.

MS. DECKER: Professional services are inconsistent with what you just said.

MS. O'SULLIVAN: Then the whole thing --

MS. FINBERG: Leave out hospital.

DR. ENTHOVEN: Well, we don't want --

MS. O'SULLIVAN: It seems like those --

DR. ENTHOVEN: We don't want an individual doc to be at risk for hospitals.

MR. ZATKIN: That would be prohibited anyway.

THE REPORTER: Excuse me.

MS. SINGH: The court reporter is unable to catch 15 voices at once.

MR. ZATKIN: The issue here, just to make it a little more uncomplicated is, if the physician is at risk for his or her own services and then takes risk for one little referral class versus a lot of the full cost for professional referral service.

MS. O'SULLIVAN: So then, do you mean pharmaceutical in lab services and specialty, but obviously not hospitalization?

MR. ZATKIN: Right. But what I'm saying is, that there is a policy issue about whether we are prohibiting an arrangement in which the physician has taken risk for all of the professional services or just, say, one.

MEMBER: Keep lab --

MR. ZATKIN: Yeah, keep lab --

MR. RODGERS: That was what I was going to say. You have some scope of practice that allows you to serve that patient, you don't make the referral, and that's in the capitation. They we're not talking about

those kinds of issues where a person is going to refer an individual type of problem or keep an individual type of problem.

Is that correct? Because if you're incentivizing a person because of their scope of practice, that they will do that; that happens a lot in the contracts now. You will do the lab or you will do certain types of procedures, we're not going to pay for it if it goes out for your referral. So the physician is at risk, in essence.

Is that what we're talking about?

MS. DECKER: Give examples.

DR. SPURLOCK: We need a lot of clarity of exactly what we're talking about because it's the fuzzy area. Unless we get really specific about --

MR. RODGERS: I'll give you an example. The family practitioners, typically you get those kinds of things where they were saying that is a service and we're paying your primary care physician for

DR. GILBERT: But to a point, Tony, and I think what we're talking about on a professional side when you make a referral to another physician for a specialty consultation, that's out; but the issue might be capped for lab -- for lab meaning also external lab as well as lab you can do on-site, pharmaceuticals are an off-site. But I think if we talk about what can be done at the physician's office within his or her service and scope of practice and outside, the question that Steve's raising,

are we talking about all those things that go outside, is that the threshold or is it pieces of thing?

MS. SINGER Is it sufficient to say professional -- I'm sorry -- capitation payment for services other than those who provides directly?

MS. SKUBIK: Isn't the issue that you all are concerned about is the relative magnitude of the incentives such that you don't want an overly stringent incentive on an individual doctor, that maybe you're talking about limiting a percentage of the income that's affected by an incentive -- you don't want to say no incentives.

DR. ENTHOVEN: This just says capitation. This is cap. So I was wondering about just your question, Hattie, that is, the doctor could still be at risk for 10 percent of the gross costs of all the things of his other patients up to 20 percent of his income or something, you know, some formula like that would not be ruled out.

MR. ZATKIN: We're not writing a statute here, but it's important to provide some guidance as to what we mean and that's why I raised it. You need to be aware of it.

DR. GILBERT: We're talking about physicians being paid in advance for any services he could potentially refer out; therefore, every time he chooses not to refer something out, he retains that cash because otherwise that money would have to be paid out to that outside provider.

DR. KARPF: Does that mean there can't be any risk pool sharing?

DR. ENTHOVEN: No.

DR. GILBERT: IV A only talks about capitation.

MR. WILLIAMS: And this applies both to health plans to which health plans have control and then also to medical groups and IPAs and relationships they have.

MS. SINGH: We need to take a one-minute break.

(Break.)

MEMBER: Here we have three issues; quality, service, and I would hope we wouldn't eliminate efficiency out of this equation.

MR. ZATKIN: Conceptually the differences between professional services and ancillaries, as you described --

DR. ALPERT: Point of clarification. Steve, isn't this to address a case such as the healthy young male comes in and sees the doctor, the doctor puts the stethoscope on his chest and hears a heart murmur, and he immediately calculates because of his exposure of that capitation arrangement what that murmur is going to cost in terms of surgery that was unexpected in this 28 year old man and all of a sudden the heart murmur gets a little less and doesn't sound so loud. What's to prevent that?

DR. SPURLOCK: The line is that some people

that have -- our primary care practitioners do have a fair amount of specialty care and are very efficient and an incentive to learn to get better at that. So for example, in our group doing ingrown toenails, something that a podiatrist could do is something now that your incented to do; and so you get better --

DR. GILBERT: Then you ask for a bigger primary cap in providing more services within your primary cap. But what we're talking about is when the physician is directly responsible for the payment -- I mean, out of that capitation that is received; so I think of it as we're concerned about the primary care doc having a specialty cap, that he gets or she gets the specialty cap protection.

MR. ZATKIN: If you were writing a statute, you would have to say something like, these arrangements need to be submitted, these types of relationships need to be submitted for review, and then you would say that the regulatory agency either may or shall prohibit such arrangement where it determines that it represents a substantial risk for the cost of professional services.

DR. SPURLOCK: I think that allows flexibility or for changes.

MR. ZATKIN: Well, I said either it may or shall. This is a shall.

DR. KARPF: Are we talking about circumstances that exists or a theoretical circumstance? I'm not seeing a cap program administered that way at a

group level or IPA level.

DR. ALPERT: The case I described is an actual case.

DR. ENTHOVEN: Michael, my interest in it was I'd like to get these damn horror stories out of the newspapers where people invent this thing that doesn't exist or write a story condemning it. If we just had it clear it was in the law, that didn't happen, it would help clear the air.

MS. SKUBIK: Dr. Alpert, would this language -- (inaudible.)

DR. ALPERT: No. I think this -- that's why I asked. This gets rid of something that I know has existed in the system and formerly doctors get out because of it.

DR. ENTHOVEN: IV B. We're just about --

MS. SINGH: IV A is --

DR. ENTHOVEN: IV A is okay now.

Uh, Steve?

Okay. IV B. Couple of just friendly thoughts. One is small group, it might be helpful to put five or less and something about the periodicity issue which we talked about.

MR. LEE: We suggest adding a new letter to periodicity rather than having that folded into B.

DR. ENTHOVEN: If we just say we agree that we want that touched on, the concept touched on.

MR. ZATKIN: It really belongs in --

DR. ENTHOVEN: It belongs where?

MR. PEREZ: B sub one and B sub two.

DR. ENTHOVEN: Then IV C? Straw vote on that, applying the federal rule?

MR. HARTSHORN: Stop loss. I'll vote for the stop loss, not the federal rule.

MS. SINGER Only stop loss, not the survey.

DR. ENTHOVEN: Now, recommendation five?

MR. LEE: As amended.

DR. ENTHOVEN: As amended?

MR. HARTSHORN: What's the amendment?

MR. LEE: That was the one we talked about earlier -- also incentivizing quality. That was Michael's language.

DR. KARPF: Quality and service.

MR. LEE. Quality and service.

MR. HARTSHORN: Why don't we combine it?

MS. FINBERG: I wanted to add consumer groups to six.

MR. LEE: Which I think is a great benefit to the antitrust problems. It's making it a public process. It's just not the industry sitting down and watching themselves.

DR. ENTHOVEN: Do they have to do this subject to the open meetings?

(Laughing.)

DR. ENTHOVEN: Without objection, five is okay as amended.

Then six, consumer groups which we'll call immunize people from antitrust.

Seven is about risk adjustment which I think we've --

MR. ZATKIN: It doesn't belong.

DR. ENTHOVEN: It doesn't belong, yeah.

Thank you all very --

MR. LEE: Wait. One recommendation is before the recommendations --

MS. FINBERG: We straw polled everything else. Was there a reason we didn't straw poll five and six?

MR. PEREZ: We did.

MS. FINBERG: I'm sorry.

MR. LEE: I'd like to suggest that the one sentence before recommendations, the department would benefit from, we add that as a recommendation because really, you can't do a lot of what's in here without the department or whoever it is having the requisite expertise. And so I just recommend that we make that a recommendation; that the department or whoever it is have the requisite expertise to adequately assess compensation arrangements.

DR. ROMERO: Take the last sentence before Roman II and move this down into the recommendation?

MR. LEE: Yes. Move it as a numbered recommendation for the requisite expertise.

DR. KARPF: Can I make a comment about

No. 6?

DR. ENTHOVEN: Yes, Dr. Karpf?

DR. KARPF: In principle I agree with six; however, I think as we go through these we're setting up a number of good committees from a variety of different places and they's out there in orbit on their own, it's not clear who's appointing them, who they're reporting to, or how they constituted the need to anchor into some kind of body.

DR. ENTHOVEN: What I'm hoping is that in reading this, anyway, what I thought is just these people would get together and start talking with each other and sorting out and coming to agreement as to what's good practice and what's not.

DR. KARPF: I'm saying that maybe happen, but if there's a body that says, let's bring this group together, we're going to get a report back from it, then it's much more likely to happen.

DR. ENTHOVEN: You mean like DOC?

MEMBER: Or DHS.

DR. KARPF: DOC or some new regulatory board. Because we have a number of these things out -- we're putting out there in orbit so we're cluttering the atmosphere with public good space junk.

DR. ROMERO: They need a customer.

MS. SINGH: Before we go to public comments, Members, a very few clarifying issues. First of all, tomorrow morning's meeting begins promptly at 8:00 a.m.

Please bring your meeting packet with you because we will be discussing three of the papers that were originally tabled for today's meeting and we were unable to get to them. They are on the agenda for tomorrow.

DR. ROMERO: Alice, just a footnote. Correct me if I'm wrong, I'm told that this room is secure enough that you can leave nonvaluable things at your seats.

(Laughter.)

MS. SINGH: The meeting will be held in this room.

DR. ENTHOVEN: Before anyone else goes, let me just thank you all very much. This went a whole lot better than my expectation.

(Applause.)

MS. FINBERG: I want to mention that the meeting on the 25th is not going to be at the Hyatt. In case people that aren't coming here tomorrow --

MS. SINGH: Tuesday's meeting will be held in the convention center, the Sacramento convention center in room 204. Use the K Street entrance.

MEMBER: Where is the convention center?

MS. SINGH: The convention center is just across the street from the Hyatt.

DR. KARPF: Will you be distributing a new agenda after we see what we've accomplished tomorrow?

DR. ENTHOVEN: I think we've had to notice that already.

MS. SINGH: The agenda has been supplied.

MEMBER: It's 1400 J Street.

MS. SINGH: Room 204 at 8:30 a.m., Tuesday.

DR. ENTHOVEN: Maureen?

MS. O'HAREN: I know it's late, I'll be very quick and on point.

And since Mr. Shapiro was kind enough to hold me off to the end and he was kind enough to withdraw some of his suggestions, I won't go after some of his suggestions which we do have serious -- (inaudible.)

I think basically the discussion that I heard, that the one thing that still remains a concern is the extension of the federal rules to California and the commercial market and what that will entail. Dr. Spurlock noted that groups that have more than 25,000 lives would automatically be considered okay. What that means is smaller groups have to do these onerous calculations.

If any of you are familiar with the federal regulations in terms of what the providers and plans have to do, how they calculate substantial financial risk, there's multiple levels and there's complex calculations you have to go through and burdensome reporting obligations that have to go up the chain. And while you could say, oh, well, but they're already doing it in the MediCare program, the financial arrangements between MediCare risk product and commercial products are different. So everybody would have to go through these calculations all over again.

I would urge in adopting this stop loss requirement, extending this federal rule regarding stop loss, you simply say that a plan can either do this reporting or just do the stop loss, require the stop loss of their providers.

MR. ZATKIN: We didn't adopt it.

MS. O'HAREN: Pardon?

MR. ZATKIN: We didn't adopt it.

MS. O'HAREN: Well, I thought Mr. Shapiro -- some of his suggestions in his memo led -- the recommendation isn't clear, Steve, and I was still concerned about what you meant when you said extend the federal rule. The federal rule contains --

MR. SHAPIRO: Only the stop loss.

DR. ENTHOVEN: Let's be sure we clarify the wording.

MS. O'HAREN: And the other issue is the disenrollment issue, the extension that you must understand, a lot of people leave health plans because employers drop. It's different from the MediCare market when the individual has their choice.

MR. SHAPIRO: It's gone.

MS. O'HAREN: I guess one last point is the amendment that was -- its existing language amended by Mr. Shapiro regarding purchasers reviewing provider incentive arrangements. It was included with the accreditation organization. But I think it would be more appropriate if you accredited organizations with the ones

to look at this. Purchasers can, if they want, require plans to submit all their contracts; but we're getting into a situation where purchasers are becoming quasi regulators and that's raising costs.

Rather than, I think, having the industry group looking at these things, but NCQA and some of these other organizations identify gold standards and use that in the accrediting process would be a better way to go than having various large purchasers decide what's good and what's bad and try to tell different plans different things to do and have some inconsistencies within the market which would make it difficult for accrediting organizations to operate.

DR. ENTHOVEN: Okay. Thank you.

Catherine Dodd, American Nurse's Association.

MS. DODD: I just wanted to point out that in the recommendation No. 6 and in other blue ribbon task forces that get blotted out there and shot up into the sky, it would be nice if we would request, formally request that not only be in the California Medical Association but nursing organizations be represented on those task forces, as well nurse practitioners have notoriously been cut out of some of the arrangements and we can figure out a per member per month amount.

We also support the idea of adding the quality indicators and the incentive based on quality and believe that that will add to our incentive.

DR. ENTHOVEN: Thank you.

I just wonder if we want to give some guidance to the drafters of the paper on that last suggestion.

MR. WILLIAMS: On the prior comment, I had a comment on the prior comment. The one point I think we all should keep in mind is that in administering the MediCare risk program, you're talking about a program that has a premium between 4- and $500 a month. Therefore, if you have 10 percent administrative costs on that, you're talking about $40 or $50 a month to cover all of the paperwork and administration. When you talk about bringing federal requirements to MediCare risk down to a commercial population where the premium may be slightly more than $100 --

DR. KARPF: Less.

MR. WILLIAMS: -- there's not the --

MR. ZATKIN: The only thing we are doing is saying if the physicians are in an arrangement which involves substantial financial risk, then they need stop loss.

MR. WILLIAMS: I think that's fine. I'm saying a broader applicability as we go through the process, we begin to say, oh, that's done for MediCare risk, let's do it for this. It's a general comment.

DR. ENTHOVEN: Our consensus is we won't say adopt the federal, we'll just state there should be stop loss when there's substantial risk leaving the feds out of

it.

MS. O'SULLIVAN: Getting back to your question giving guidance to the staff on the nursing issue. I recommend that we have doctors on panels, we have nurses or nurse organizations.

MR. ZATKIN: The subject is physician incentives.

DR. ENTHOVEN: Yes, the subject is physician incentives.

MS. DECKER: Isn't it provider incentives?

MS. SINGH: Financial incentives for physicians in managed care plans is the title.

MS. O'SULLIVAN: Well, we said we're going to move the physicians into providers. I don't know why it wouldn't be across the board. There are incentives that would be around quality.

DR. ENTHOVEN: Let's just take a quick straw vote. How many in favor of Maryann's recommendation that nursing be included? All in favor, please raise your right hand.

DR. ROMERO: On this --

MS. O'SULLIVAN: On any of the task force.

MS. BOWNE: What was the question?

MS. RODRIGUEZ-TRIAS: Inclusion of nurses.

DR. ENTHOVEN: 14 is more than the majority of who's here. Remember that we've got less than -- we have 23 people left.

MS. DECKER: We just got Rebecca, so we have

15 and you're going to vote for it, Alain, so that's 16.

(Laughing.)

DR. ENTHOVEN: I'm thinking of the cost and complexity.

The meeting is now adjourned.

(The proceedings concluded at 7:00 p.m.)

STATE OF CALIFORNIA)
) ss.
COUNTY OF LOS ANGELES)

I, Joanna Austin, CSR, RPR 10380, a certified Shorthand Reporter in and for the State of California, do hereby certify:

That the foregoing proceeding was taken down by me in shorthand at the time and place named therein and was thereafter reduced to typewriting under my supervision; that this transcript is a true record of the testimony given by the witness and contains a full, true and correct record of the proceedings which took place at the time and place set forth in the caption hereto as shown by my original stenographic notes.

I further certify that I have no interest in the event of the action.

EXECUTED this 26th day of November , 1997.

Joanna Austin, CSR #10380